

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

036938

3707

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8233 Pleasant Plains Road | | d. STREET ADDRESS 8233 Pleasant Plains Road | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle O. Last ACHENBACH | | 4. DATE OF DEATH Month April Day 7 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 9, 1869 |
| 9. AGE (In years last birthday) 88 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logger | |
| 10b. KIND OF BUSINESS OR INDUSTRY Lumber Business | | 11. BIRTHPLACE (State or foreign country) Buffalo City, Wisconsin | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME William Achenbach | |
| 14. MOTHER'S MAIDEN NAME Ottillie Heck | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----- | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs. George J. Sills, 8233 Pleasant Plain Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerosis DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1953 , 19____, to 4/5/57 , 19____, that I last saw the deceased alive on 4/5/57 , 19____, and that death occurred at 7:11 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Dennis J. McGrath M.D. | | ADDRESS (Street, city or town, state) 8358 Loch Raven Blvd. Towson, Md. | |
| PHYSICIAN'S NAME (Type) DENNIS J. MCGRATH | | DATE SIGNED 4/8/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4/10/57 | 22c. NAME OF CEMETERY OR CREMATORY Alma Wisconsin Cemetery | 22d. LOCATION (City, town, or county) (State) Alma Wisconsin |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS 4600 Liberty Hgts. Ave. | | 24a. REC'D BY REGISTRAR APR 9 1957 | 24b. REGISTRAR'S SIGNATURE Malcolm Gray |

RECEIVED

3697

CERTIFICATE OF DEATH

Reg. Dist. No.

47

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|--|------------------------------|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Lansdowne | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 302 First Street | | | | d. STREET ADDRESS 1 302 First Street | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM Z. ACTON | | | | 4. DATE OF DEATH Month Day Year 4/2/57 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/31/75 | 9. AGE (In years last birthday) 81 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Ward Baking Co. | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Christopher | | | | 14. MOTHER'S MAIDEN NAME Margaret Roubough | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family - Same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Branchio-pneumonia terminal DUE TO chr Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arterio sclerosis DUE TO (c) 329 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 mo Parkinson's Disease | | | | INTERVAL BETWEEN ONSET AND DEATH 329 | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 1952 to Apr 1957 , that I last saw the deceased alive on Apr 22, 1957 , and that death occurred at 4 P. M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE B B Brumbaugh M.D. 5609 main St Ellicott City | | | | ADDRESS (Street, city or town, state) DATE SIGNED 4/3/57 | | | |
| PHYSICIAN'S NAME (Type) B B Brumbaugh | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) B | | 22b. DATE THEREOF 4/5/57 | | 22c. NAME OF CEMETERY OR CREMATORY Lorraine | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE McCully Funera; Homes - I30 E. Fort Avenue | | | | 24a. REC'D BY REGISTRAR APR 5 1957 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE Dr. M. Kieffer | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | |
|------------------------|--|-----------------------|--|
| PLACE OF DEATH | | MARRIAGE | |
| DATE OF DEATH | | DATE OF MARRIAGE | |
| AGE | | SEX | |
| RACE | | EDUCATION | |
| OCCUPATION | | RELIGION | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| DATE OF BURIAL | | PLACE OF BURIAL | |
| SIGNATURE OF REGISTRAR | | SIGNATURE OF DECEASED | |
| DATE OF REGISTRATION | | PLACE OF REGISTRATION | |
| FEE | | REMARKS | |

BUREAU V. S.

APR 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03694
31

3708 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1523 Woodcliff Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOSEPH ALOYSIUS AMER, SR. | | 4. DATE OF DEATH Month April Day 12 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 2, 1897 |
| 9. AGE (In years last birthday) 59 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer | |
| 10b. KIND OF BUSINESS OR INDUSTRY American Oil Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Henry Amer | |
| 14. MOTHER'S MAIDEN NAME Mary Elizabeth Caldwell | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----- | |
| 16. SOCIAL SECURITY NO. 217-03-8418 | | 17. INFORMANT Elizabeth J. Amer-1523 Woodcliff Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma liver (metastatic) 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary carcinoma colon DUE TO (c) Unknown | | INTERVAL BETWEEN ONSET AND DEATH Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-19 , 19 52 , to 4-12 , 19 57 , that I last saw the deceased alive on 4-9 , 19 57 , and that death occurred at 2:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fredricks Rd., Catonsville, Maryland DATE SIGNED 4-15-57 | | | |
| ACTUAL SIGNATURE Stephen Lee Magness M.D. | | PHYSICIAN'S NAME (Type) STEPHEN LEE MAGNESS | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/16/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | | 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost | | 24. REG'D BY: REGISTRAR Dr. Jm. J. Martin | |
| 24b. REGISTRAR'S SIGNATURE | | DATE APR 17 1957 | |

BUREAU V. S.

APR 17 1957

RECEIVED

3709

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 2yr5mth6dys | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac Heights, Maryland | | d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | |
| d. STREET ADDRESS 56 Circle Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Roland Middle Lewis Last Austin | | 4. DATE OF DEATH Month 4 Day 12 Year 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 21, 1894 |
| 9. AGE (In years last birthday) yrs. 63 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman installer | | 10b. KIND OF BUSINESS OR INDUSTRY Western Electric Co. Maryland | |
| 11. BIRTHPLACE (State or foreign country) England | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Louis Austin | | 14. MOTHER'S MAIDEN NAME Emily Cash | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW#1 | | 16. SOCIAL SECURITY NO. 053-01-6996 | |
| 17. INFORMANT Records; SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 21, 19 57 , to April 12, 19 57 , that I last saw the deceased alive on April 12, 19 57 , and that death occurred at 8.00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED | | | |
| ACTUAL SIGNATURE Stella Wachslar M.D. | | PHYSICIAN'S NAME (Type) STELLA WACHSLER | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | 22b. DATE THEREOF 4/13/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY | | 22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | ADDRESS SILVER SPRING, MD. | |
| 24a. REC'D BY REGISTRAR APR 15 '57 | | 24b. REGISTRAR'S SIGNATURE West | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 38

3710

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson | | c. LENGTH OF STAY IN 1b 6 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Valley Road | | | | d. STREET ADDRESS Valley Road | | | |
| 3. NAME OF DECEASED (Type or print) First Josephine Middle Stewart Last Baetjer | | | | 4. DATE OF DEATH Month April Day 24 Year 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 19, 1950 | | 9. AGE (In years last birthday) 6 yrs. | IF UNDER 1 YEAR Months 6 Days 0 | IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Howard Baetjer, II | | | | 14. MOTHER'S MAIDEN NAME Katherine Finney | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Md. Howard Baetjer, II- Valley Rd., Stevenson, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonia (Virus) 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) (County) (State) none | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE D. D. Caples | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-25-57 | | 22c. NAME OF CEMETERY OR CREMATORY St. Thomas | | 22d. LOCATION (City, town, or county) (State) Garrison Forest, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc., 1900 E. Baltimore, Md. | | | | 24a. REC'D BY REGISTRAR Dr. A. M. Bacht | | 24b. REGISTRAR'S SIGNATURE Dr. A. M. Bacht | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-----------------------|--|-------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| AGE | | SEX | |
| RACE | | OCCUPATION | |
| RESIDENCE | | PLACE OF DEATH | |
| MANNER OF DEATH | | CAUSE OF DEATH | |
| MEDICAL HISTORY | | POST-MORTEM EXAMINATION | |
| FAMILY HISTORY | | LABORATORY EXAMINATIONS | |
| SIGNATURE OF EXAMINER | | DATE | |

BUREAU V. 3

1957

RECEIVED

3711

CERTIFICATE OF DEATH

Reg. Dist. No.

32

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|---|-------------------------------|--|--------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Pikesville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2106 Plymouth Rd.</u> | | | | d. STREET ADDRESS <u>2106 Plymouth Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Edward Keefer Baker, Sr.</u> | | | | 4. DATE OF DEATH <u>April 28 1957</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 2, 1879</u> | 9. AGE (In years last birthday) <u>77</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner of General Store</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>George F. Baker</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ella Keefer</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <u>Mrs. Nellie Baker - 2106 Plymouth Rd</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> (c) <u>Ar. sclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>1 yr.</u> <u>1 yr.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>April 1, 1956</u> to <u>April 28, 1957</u> that I last saw the deceased alive on <u>April 22, 1957</u> and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>James A. Miller, Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Pikesville - Md</u> | | | |
| DATE SIGNED <u>4/29/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. James A. Miller</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>April 30, '57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u> | | 22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury - 6411 Windsor Mill Rd</u> | | | | ADDRESS <u>6411 Windsor Mill Rd</u> | | 24a. REC'D BY REGISTRAR <u>May 3 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Donna M. M...</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

MAY 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3712

CERTIFICATE OF DEATH

Reg. Dist. No.

03698

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 5 DAYS | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | ✓ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 1617 AISQUITTH STREET | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last BAKER | | 4. DATE OF DEATH Month APRIL Day 9 Year 1957 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 10, 1897 9. AGE (In years last birthday) 59 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HUCKSTER | | 10b. KIND OF BUSINESS OR INDUSTRY FRUIT & VEGETABLES | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT CLIN. REC., VET. ADM. HOSPITAL, FT. HOWARD, MARYLAND | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X CEREBRAL THROMBOSIS, LEFT, WITH RIGHT HEMIPARESIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 250X (b) XXXX DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS- Duration unknown INTERVAL BETWEEN ONSET AND DEATH 6 DAYS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 4, 19 57, to April 9, 19 57, and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 4/10/57 ACTUAL SIGNATURE Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service VETERANS ADMINISTRATION HOSPITAL | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-15-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. ADDRESS 6009 Warford Road, Balto. 14 | | 24a. REC'D BY REGISTRAR APR 17 1957 24b. REGISTRAR'S SIGNATURE James L. Fackey | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|-----------------|--|---------------------------|--|-------------|--|------------------------|--|-------------------|--|----------------------|--|-------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. HARRIS | | 65 | | M | | W | | JAN 15 1892 | | BALTIMORE | | MD | | USA | |
| MARRIAGE | | DATE | | PLACE | | CITY | | COUNTRY | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| MARRIED | | JAN 15 1915 | | BALTIMORE | | MD | | USA | | JAN 15 1957 | | BALTIMORE | | MD | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY OF INTERMENT | |
| HEART DISEASE | | NATURAL | | LABORER | | HIGH SCHOOL | | METHODIST | | JAN 15 1957 | | BALTIMORE | | MD | |
| SIGNATURE OF PHYSICIAN | | DATE | | SIGNATURE OF FUNERAL HOME | | DATE | | SIGNATURE OF REGISTRAR | | DATE | | SIGNATURE OF WITNESS | | DATE | |
| JAMES H. HARRIS | | JAN 15 1957 | | JAMES H. HARRIS | | JAN 15 1957 | | JAMES H. HARRIS | | JAN 15 1957 | | JAMES H. HARRIS | | JAN 15 1957 | |

BUREAU V. 1

APR 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3713 CERTIFICATE OF DEATH

03699
Reg. Dist. No. 33

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary Ann Baker | | 4. DATE OF DEATH Month Day Year April 19 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/14/55 |
| 9. AGE (In years lost birthday) yrs. 1 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | 11. BIRTHPLACE (State or foreign country) Mercy Hospital Balt. M.D. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Leonard J. Baker | |
| 14. MOTHER'S MAIDEN NAME Mary Regina McBride | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Parents - 2718 Wooddale Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 752x Aspiration pneumonia bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hydrocephalus, congenital (Arnold-Chiari) DUE TO (c) Multiple congenital anomalies PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 3/29 to 4/19, 1957, that I last saw the deceased alive on 4/19, 1957, and that death occurred at 8:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Harry G. Butler M.D. ADDRESS (Street, city or town, state) Owings Mills, Md. DATE SIGNED 22 Apr. 57 PHYSICIAN'S NAME (Type) Harry G. Butler M.D. Owings Mills, Md. | | INTERVAL BETWEEN ONSET AND DEATH 1/9/57-4/19/57 Birth - Birth - | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/24/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14 | | 24a. REC'D BY REGISTRAR DATE 4/25/57 | |
| 24b. REGISTRAR'S SIGNATURE Mary Elmer | | | |

BUREAU V. 31

PR 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03700

3714

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo. Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b Pyrlmt2ldys | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Washington, D. C.) 16x22 | | d. STREET ADDRESS 3126-28th St. - S. E. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Herman Middle W. Last Balderson | | 4. DATE OF DEATH Month APRIL Day 11 Year 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 7, 1900 |
| 9. AGE (In years last birthday) 56 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown | | 10b. KIND OF BUSINESS OR INDUSTRY Virginia | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Benjamin Balderson | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 141X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Congestion & Hypostasis DUE TO (c) Carcinoma base of the Tongue & multiple metastases | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 21, 1954 , to April 11, 1957 , that I last saw the deceased alive on April 11, 1957 , and that death occurred at 7:45 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslor M.D. SPRING GROVE STATE HOSPITAL 4-11-57 | | | |
| ACTUAL SIGNATURE | | PHYSICIAN'S NAME (Type) Stella Wachslor, M. D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4-13-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem. | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Farnsworth Home 7441-11th St. D.C. | | 24a. REC'D BY REGISTRAR DATE APR 16 '57 | |
| 24b. REGISTRAR'S SIGNATURE W. Farnsworth | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-----------------------|--|-------------------|--|----------------|--|-----------------|--|----------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES J. JONES | | 45 | | M | | W | | 1912 | | MASSACHUSETTS | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| 1000 Main St., Boston | | Carpenter | | Heart Disease | | Natural | | April 15, 1957 | | Boston, Mass. | |
| FATHER'S NAME | | MOTHER'S NAME | | EDUCATION | | RELIGION | | MARRIAGE | | SINGLE | |
| JAMES J. JONES | | MARY J. JONES | | High School | | Roman Catholic | | Married | | Single | |
| DATE OF MARRIAGE | | PLACE OF MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| April 10, 1945 | | Boston, Mass. | | April 15, 1957 | | Boston, Mass. | | April 15, 1957 | | Boston, Mass. | |
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| April 15, 1957 | | Boston, Mass. | | April 15, 1957 | | Boston, Mass. | | April 15, 1957 | | Boston, Mass. | |
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| April 15, 1957 | | Boston, Mass. | | April 15, 1957 | | Boston, Mass. | | April 15, 1957 | | Boston, Mass. | |

BUREAU V. 3

APR 16 1957

RECEIVED

3715

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home 1002 N. Rolling Rd. | | d. STREET ADDRESS 1606 Manerdene Rd. | |
| 3. NAME OF DECEASED (Type or print) MARY NESBITT BAUER | | 4. DATE OF DEATH April 3, 1957 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 27, 1879 |
| 9. AGE (In years last birthday) 77 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (rtd) | | 10b. KIND OF BUSINESS OR INDUSTRY Balto. Public School Md. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Jonathan Nesbitt | | 14. MOTHER'S MAIDEN NAME Virginia Runkey (?) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mr. Charles Bauer-5513 Leith Rd. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Ed paralysis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 1, 1957 to April 3, 1957 , that I last saw the deceased alive on April 1, 1957 , and that death occurred at 1 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4508 71 Charles St Baltimore Md. DATE SIGNED | | | |
| ACTUAL SIGNATURE Charles S. Tibbitt | | M.D. 4508 71 Charles St Baltimore Md. | |
| PHYSICIAN'S NAME (Type) Charles S. Tibbitt | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4/6/57 | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | 22d. LOCATION (City, town, or county) (State) Balto., Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Mr. J. Tiekner & Sons - Baltor 17 Md | | 24a. REC'D BY REGISTRAR APR 8 '57 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE W. L. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8712

MD-100 (Rev. 1-54)

| | | | | | | | | | |
|---|--|---------------------------------------|--|--|--|--|--|---------------------------------------|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | | 4. DATE OF BIRTH 12-5-20 | | 5. PLACE OF BIRTH MOBILE, ALA. | |
| 6. OCCUPATION None | | 7. MARITAL STATUS Single | | 8. COLOR White | | 9. HEIGHT 5' 10" | | 10. WEIGHT 175 | |
| 11. EDUCATION High School | | 12. RELIGION None | | 13. US BIRTH Yes | | 14. ALIEN STATUS None | | 15. SOCIAL SECURITY NUMBER None | |
| 16. DECEASED'S ADDRESS 2812 1/2 N. 2nd St., Memphis, Tenn. | | 17. DECEASED'S PHONE None | | 18. DECEASED'S MAILING ADDRESS None | | 19. DECEASED'S MAILING PHONE None | | 20. DECEASED'S MAILING CITY None | |
| 21. DECEASED'S STATE Tenn. | | 22. DECEASED'S COUNTY Shelby | | 23. DECEASED'S CITY Memphis | | 24. DECEASED'S ZIP CODE 38103 | | 25. DECEASED'S DISTRICT None | |
| 26. DECEASED'S ZIP CODE 38103 | | 27. DECEASED'S DISTRICT None | | 28. DECEASED'S COUNTY Shelby | | 29. DECEASED'S STATE Tenn. | | 30. DECEASED'S COUNTRY USA | |
| 31. DECEASED'S RACE White | | 32. DECEASED'S COLOR White | | 33. DECEASED'S HEIGHT 5' 10" | | 34. DECEASED'S WEIGHT 175 | | 35. DECEASED'S BUILD Slender | |
| 36. DECEASED'S EYES Blue | | 37. DECEASED'S HAIR Brown | | 38. DECEASED'S COMPLEXION Fair | | 39. DECEASED'S SCARS None | | 40. DECEASED'S TATTOOS None | |
| 41. DECEASED'S DISEASES None | | 42. DECEASED'S CAUSE OF DEATH None | | 43. DECEASED'S MANNER OF DEATH None | | 44. DECEASED'S PLACE OF DEATH None | | 45. DECEASED'S TIME OF DEATH None | |
| 46. DECEASED'S DATE OF DEATH None | | 47. DECEASED'S TIME OF DEATH None | | 48. DECEASED'S PLACE OF DEATH None | | 49. DECEASED'S MANNER OF DEATH None | | 50. DECEASED'S CAUSE OF DEATH None | |
| 51. DECEASED'S DISEASES None | | 52. DECEASED'S CAUSE OF DEATH None | | 53. DECEASED'S MANNER OF DEATH None | | 54. DECEASED'S PLACE OF DEATH None | | 55. DECEASED'S TIME OF DEATH None | |
| 56. DECEASED'S DATE OF DEATH None | | 57. DECEASED'S TIME OF DEATH None | | 58. DECEASED'S PLACE OF DEATH None | | 59. DECEASED'S MANNER OF DEATH None | | 60. DECEASED'S CAUSE OF DEATH None | |

BUREAU V. 2

APR 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3716

CERTIFICATE OF DEATH

03702

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel Co. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN lb 29days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | e. STREET ADDRESS 134 Spaview Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First Daisy Middle Maria Last Carr | | | | 4. DATE OF DEATH Month 4 Day 9 Year 19 57 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 18, 1880 | |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Henry Carr | | | | 14. MOTHER'S MAIDEN NAME Annie Carr | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour _____ a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from March 6 , 19 57 , to April 9 , 19 57 , that I last saw the deceased alive on April 9 , 19 57 , and that death occurred at 2:45p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 4/9/57 | | | | | | | |
| ACTUAL SIGNATURE Stella Wachsler | | | | M.D. SPRING GROVE STATE HOSPITAL | | | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | | | Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 22b. DATE THEREOF 4-12-57 | | 22c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF | | 22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons | | | | ADDRESS Annapolis, Md. | | 24a. REC'D BY REGISTRAR DATE 4/10/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE J. J. - U. Branch | | | |

RECEIVED

APR 11 1957

BUREAU V. 3

V.
15M

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the hospital or attending physician.
JR: After this certificate has been signed by the o

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

3717

MEDICAL CERTIFICATION

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3718

CERTIFICATE OF DEATH

Reg. Dist. No.

037032

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY BALTIMORE COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOUNT WILSON | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY 31, 3V 01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MOUNT WILSON STATE HOSPITAL | | | | d. STREET ADDRESS 2103 E. ESSEX STREET | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM BOROWIAK | | | | 4. DATE OF DEATH Month Day Year APRIL 29 1957 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC. 22 1895 | |
| 9. AGE (In years last birthday) 61 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS OPERATOR | | | | 10b. KIND OF BUSINESS OR INDUSTRY BALTO TRANSIT CO | | 11. BIRTHPLACE (State or foreign country) POLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME LAWRENCE BOROWIAK | | | | 14. MOTHER'S MAIDEN NAME MARY ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 213-10-1296 | | 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 94 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from APRIL 6, 1957 , to APRIL 29, 1957 , that I last saw the deceased alive on APRIL 29, 1957 , and that death occurred at 8:30 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE William Newcomer M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) WILLIAM NEWCOMER, M. D., SUPERINTENDENT | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF MAY 3, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY | | 22d. LOCATION (City, town, or county) (State) German Hill Rd. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber ADDRESS 705 So Ann st | | | | 24a. REC'D BY REGISTRAR MAY 2 1957 | | 24b. REGISTRAR'S SIGNATURE Anthony Newell | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

MAY 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3719

CERTIFICATE OF DEATH

03705

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville | | | | c. LENGTH OF STAY IN 1b 2½ yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ella Frances Scott Bosley | | | | 4. DATE OF DEATH Month Day Year 4-5-57 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-6-1870 | 9. AGE (In years last birthday) 87 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edwin Scott | | | | 14. MOTHER'S MAIDEN NAME Eleanor A.B. Scott | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Nellie V. Orcutt Address 106 Allegheny Ave. Towson 4, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonitis DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21. I certify that I attended the deceased from December 1956 to April 5th 1957 , that I last saw the deceased alive on April 5th 1957 , and that death occurred at 10:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1927 York Rd. TIMONIUM, Md. 4/6/57 | | | | | | | |
| ACTUAL SIGNATURE M. X Quinn M.D. | | | | PHYSICIAN'S NAME (Type) M. KEVIN QUINN | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-8-57 | | 22c. NAME OF CEMETERY OR CREMATORY Sherwood Episcopal | | 22d. LOCATION (City, town, or county) (State) Cockeysville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks | | | | 24a. REC'D BY REGISTRAR DATE 9 1957 | | 24b. REGISTRAR'S SIGNATURE L. H. Hedrick | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03706

3720

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1yr9mthl1dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS 761 Grantley St. | |
| 3. NAME OF DECEASED (Type or print) First Agnes Middle Marie Last Bourne | | 4. DATE OF DEATH Month 4 Day 5 Year 19 57 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 29, 1878 |
| 9. AGE (In years last birthday) yrs. 78 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY housework | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME William Turnt | | 14. MOTHER'S MAIDEN NAME Louisa Casper | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records: | | Address SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Urinary cystitis DUE TO (c) ? | | INTERVAL BETWEEN ONSET AND DEATH 4mo plus | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 2, 1957 to 4/5 , 19 57 , that I last saw the deceased alive on 4/5 , 19 57 , and that death occurred at 6:25 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Stella Wachslar | | M.D. SPRING GROVE STATE HOSPITAL | |
| PHYSICIAN'S NAME (Type) STELLA WACHSLER | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| Burial | | April 9, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| London Park | | Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frederic A. Cole | | ADDRESS 1913 W. Balto St #23 | |
| 24a. REC'D BY REGISTRAR DATE APR 8 57 | | 24b. REGISTRAR'S SIGNATURE W. J. Smith | |

BUREAU V. S.

APR 8 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3721

CERTIFICATE OF DEATH:

Reg. Dist. No.

03707
44

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard | | | | c. LENGTH OF STAY IN 1b 19 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First RUFUS Middle C Last BRANNOCK | | | | 4. DATE OF DEATH Month April Day 6 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/25/89 | |
| 9. AGE (In years last birthday) 67 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Rennie Brannock | | | | 14. MOTHER'S MAIDEN NAME Mary Rachel Stanley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 220-12-1247 | | 17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS RIGHT SIDE 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive CV Disease. Left Hemiplegia due to Cerebral Thrombosis Rt Side 443x INTERVAL BETWEEN ONSET AND DEATH 5 WEEKS UNKNOWN | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 18 , 19 57 , to April 6 , 19 57 , and that death occurred at 9:20 A . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 4/7/57 ACTUAL SIGNATURE Armen Bogosian M.D. PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M. D. Fort Howard, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/10/1957 | | 22c. NAME OF CEMETERY OR CREMATORY Taylor's Island Cemetery | | 22d. LOCATION (City, town, or county) (State) Taylor's Island, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. St. Louis Jr. ADDRESS Cambridge, Md. | | | | 24a. REC'D BY REGISTRAR ADD 11 1957 | | 24b. REGISTRAR'S SIGNATURE Lawson L. Farkley | |

RECEIVED

APR 11 1957

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3722

CERTIFICATE OF DEATH

Reg. Dist. No.

03708
44

| | | | |
|--|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE Edson Avenue 3 Vo 1-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 832 EDMONDSON AVENUE | |
| 3. NAME OF DECEASED (Type or print) First GEORGE Middle P. Last BRAXTON | | 4. DATE OF DEATH Month APRIL Day 20 Year 1957 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-6-91 |
| 9. AGE (In years last birthday) 66 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR | | 10b. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS BRAXTON | | 14. MOTHER'S MAIDEN NAME AMELIA MASON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1 | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASES 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONITIS, RIGHT AND LEFT LOWER LUNG | | INTERVAL BETWEEN ONSET AND DEATH 18 MONTHS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from DEC. 16, 1956 to APRIL 20, 1957 and that death occurred at 1:55 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 4/20/57 | | | |
| ACTUAL SIGNATURE <i>Constantine J. Papastrat</i> M.D. VAH, FORT HOWARD, MARYLAND | | PHYSICIAN'S NAME (Type) CONSTANTINE J. PAPASTRAT M.D. VAH, FORT HOWARD, MARYLAND | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4-24-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE CHARLES R. LAW FUNERAL HOME 802 MADISON AVE., BALTIMORE, Md. | | 24a. REC'D BY REGISTRAR APR 24 1957 | |
| 24b. REGISTRAR'S SIGNATURE <i>Lawson L. Farber</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

APR 24 1957

RECEIVED

3723

CERTIFICATE OF DEATH

Reg. Dist. No.

03709

282

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Pikesville | | | | c. LENGTH OF STAY IN 1b 10 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MT. WILSON STATE HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last RELEFORD CRAWPH BROOKS | | | | 4. DATE OF DEATH Month Day Year APRIL 9 1957 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE INDIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-16-85 | |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARMING | | 11. BIRTHPLACE (State or foreign country) N. CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME ARON BROOKS | | | | 14. MOTHER'S MAIDEN NAME DAWSEDA LOCKLEAR | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 240-22-9669 | | 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTESTINAL OBSTRUCTION | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-25- 19 57 , to 4-9- 19 57 , that I last saw the deceased alive on 4-9- 19 57 , and that death occurred at 4:40 A.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William Newcomer M.D. | | | | ADDRESS (Street, city or town, state) MT. WILSON, Md. DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) William Newcomer | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/12/57 | | 22c. NAME OF CEMETERY OR CREMATORY Harpers Ferry | | 22d. LOCATION (City, town, or county) (State) Pembroke N.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Luther Lockler ADDRESS Pembroke, N.C. | | | | 24a. REC'D BY REGISTRAR 4/11/57 | | 24b. REGISTRAR'S SIGNATURE Glenn A. Houser Dorothy A. Houser | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

DATE OF DEATH

DECEASED

DATE OF DEATH

MACHANICUS

10 DAYS

RURAL - PRESIDENT

MT WILSON STATE HOSPITAL

WELFORD (MAY)

1900

APRIL

1957

MALE INDIAN

1-16-82

32

FARMER

FARMING

1 CAROLINA

DAVIDA L. C. C. C. C.

ARON BROOKS

AC

210-22-212

(CORONARY) THROMBOSIS

ARTERIO SCLEROSIS

INTENTIONAL CAUSE

BUREAU V. 3

APR 12 1957

RECEIVED

3724

CERTIFICATE OF DEATH

Reg. Dist. No. 42

| | | | | | | | |
|---|----------------------------------|---|---------------------------------------|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex 21 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall | | | | d. STREET ADDRESS 345 Nicholson Road | | | |
| 3. NAME OF DECEASED (Type or print) First Agnes Middle V. Last Bubb | | | | 4. DATE OF DEATH Month 4 Day 17 Year 19 57 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/29/1893 | | 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Jacob Butcher | | | | 14. MOTHER'S MAIDEN NAME Margaret Nace | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Levi W. Bubb | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO (c) ? | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.8 Arteriosclerotic heart disease | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from May 25 , 19 46 , to April 17 , 19 57 , that I last saw the deceased alive on April 16 , 19 57 , and that death occurred at 9 12 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Harvey L. Fuller M.D. | | | | ADDRESS (Street, city or town, state) Ridge Road | | DATE SIGNED April 18, 1957 | |
| PHYSICIAN'S NAME (Type) Harvey L. Fuller M.D. | | | | Baltimore 6, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/20/57 | | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore County Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. B. Bruzdinski | | | | ADDRESS 1407 Eastern Ave. | | 24a. REC'D BY REGISTRAR DATE 4/18/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Edith Hurdley | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 20 80.

RECEIVED

3725

CERTIFICATE OF DEATH

Reg. Dist. No.

03711

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b <u>1yr8mth10dys</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u> | | | | d. STREET ADDRESS <u>4605 Keswick Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>Virginia</u> Last <u>Buchman</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>19 57</u> | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 23, 1883</u> | 9. AGE (In years last birthday) yrs. <u>73</u> | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | 13. FATHER'S NAME <u>James P. Spencer</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Evans</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | |
| 16. SOCIAL SECURITY NO. <u>unknown</u> | | | | 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>55</u> , to <u>April 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>57</u> , and that death occurred at <u>7:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>4-11-57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>April 13, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u> | | | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold F. Burgee</u> ADDRESS <u>3631 Falls Rd.</u> | | | |
| 24a. REC'D BY REGISTRAR DATE <u>APR 15 '57</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>W. Search</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3726

CERTIFICATE OF DEATH

037128

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|-------------------------------------|---|--|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE PARKVILLE</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7803 ARDMORE AVE</u> | | | | e. STREET ADDRESS <u>17803 ARDMORE AVE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>E</u> Last <u>BUCHTA</u> | | | | 4. DATE OF DEATH Month <u>APRIL</u> Day <u>26</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug-27-1921</u> | 9. AGE (In years last birthday) yrs. <u>36</u> | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PACKERS</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Eugene Buchta</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MORA COLES</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>216-12-0592</u> | | 17. INFORMANT Address <u>CATHERINE K. Buchta - 1803 Ardmore Ave</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO <u>20+ yrs.</u> (c) <u>Sudden</u> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Dec 19 1955</u> to <u>Apr 26 1957</u> , that I last saw the deceased alive on <u>Apr 26 1957</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Frank T. Kasik</u> | | | | DATE SIGNED <u>4/29/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR</u> | | | | ADDRESS (Street, city or town, state) <u>9005 Hartford Rd Baltimore MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>APRIL 30-1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. F. EVANSTON</u> | | | | ADDRESS <u>8802 HARTFORD RD</u> | | | |
| 24a. REC'D BY REGISTRAR <u>MAY 2 1957</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Dr. L. M. K...</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NY 2 1957

RECEIVED
JUN 2 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3727 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03713

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u> | | | | c. LENGTH OF STAY IN 1b <u>5 Yrs.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>S t. Lukes's Rectory; 612 D Street</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Rev. John J. Callaghan</u> <u>CALLAGHAN</u> | | | | 4. DATE OF DEATH Month Day Year <u>April 9, 1957</u> <u>19</u> | | | |
| 5. SEX <u>Ma le</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 15, 1891</u> | |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roman Catholic Priest</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Daniel A. Callaghan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Nora Lane</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>Miss Aileen Callaghan- Washington, D. C.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Branchiocardia</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 Min</u> <u>5 yrs</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Jack C Collins</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>JACK C Collins</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/13/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Mora n - 3000 E. Baltimore Street</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>APR 15 1957</u> | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farless</u> | | | |

BUREAU V. S.

APR 15 1957

RECEIVED

3728

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo. Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Ranier, Maryland 16 16 2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS 3412 Newton Street | |
| 3. NAME OF DECEASED (Type or print) First Matilda Middle May Last Campbell | | 4. DATE OF DEATH Month 4 Day 27 Year 19 57 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 14, 1875 |
| 9. AGE (In years last birthday) 81 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME William Perry unknown | | 14. MOTHER'S MAIDEN NAME unknown Matilda | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio Vasc. Disease 422.1 DUE TO Arterio-sclerosis general. severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 11, 1957 , to 4/27 , 1957, that I last saw the deceased alive on 4/27 , 1957, and that death occurred at 5:51 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Stella Wachslar | | M.D. SPRING GROVE STATE HOSPITAL | |
| PHYSICIAN'S NAME (Type) STELLA WACHSLER | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Burial | 4/30/57 | Fort Lincoln Colmar Manor, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Nally's Funeral Home | | 24a. REC'D BY REGISTRAR DATE APR 30 57 | |
| ADDRESS Mt. Ranier, Md. | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | | 3. AGE [Faint text] | | 4. DATE OF BIRTH [Faint text] | |
| 5. PLACE OF BIRTH [Faint text] | | 6. OCCUPATION [Faint text] | | 7. MARITAL STATUS [Faint text] | | 8. COLOR [Faint text] | |
| 9. STREET ADDRESS [Faint text] | | 10. CITY [Faint text] | | 11. COUNTY [Faint text] | | 12. STATE [Faint text] | |
| 13. DATE OF DEATH [Faint text] | | 14. TIME OF DEATH [Faint text] | | 15. PLACE OF DEATH [Faint text] | | 16. CAUSE OF DEATH [Faint text] | |
| 17. MEDICAL HISTORY [Faint text] | | 18. PRESENT ILLNESS [Faint text] | | 19. TREATMENT [Faint text] | | 20. OTHER FACTORS [Faint text] | |
| 21. SIGNATURE OF PHYSICIAN [Faint text] | | 22. SIGNATURE OF REGISTRAR [Faint text] | | 23. SIGNATURE OF WITNESS [Faint text] | | 24. SIGNATURE OF DECEASED [Faint text] | |

BUREAU V. S.

APR 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3729

CERTIFICATE OF DEATH

03715

Reg. Dist. No.

43

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>6034 BALTIMORE AVE.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7. Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>16034 Baltimore Ave</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>EDNA V CARROLL</u> | | 4. DATE OF DEATH Month Day Year <u>4. 13 57 19</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JUNE 25. 1911</u> |
| 9. AGE (In years last birthday) <u>45</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WIFE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>JULIUS A CARROLL</u> | | Address <u>6034 BALTIMORE AVE BALTO & MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA CERVIX</u> <u>171X</u> DUE TO <u>GENITALIO RHOONAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTASIS</u> (c) <u>ANEMIA - DISTASTIA</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>4/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>57</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6800 EDWARDS AVE BALTO MD</u> ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. <u>4/15/57</u> PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW MD. BALTO. MD.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>4/17 57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM COOK INC</u> | | 24a. REC'D BY REGISTRAR DATE <u>4-15-57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Mrs. L. L. Ruffenberger</u> | | | |

RECEIVED

APR 16 1957

BUREAU V. B.

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED [REDACTED] | | 2. SEX [REDACTED] | |
| 3. AGE [REDACTED] | | 4. DATE OF BIRTH [REDACTED] | |
| 5. PLACE OF BIRTH [REDACTED] | | 6. OCCUPATION [REDACTED] | |
| 7. MARITAL STATUS [REDACTED] | | 8. CAUSE OF DEATH [REDACTED] | |
| 9. MEDICAL HISTORY [REDACTED] | | 10. SIGNATURE OF DECEASED [REDACTED] | |
| 11. SIGNATURE OF WITNESS [REDACTED] | | 12. SIGNATURE OF PHYSICIAN [REDACTED] | |
| 13. SIGNATURE OF CORONER [REDACTED] | | 14. SIGNATURE OF JURY [REDACTED] | |
| 15. SIGNATURE OF JURY [REDACTED] | | 16. SIGNATURE OF JURY [REDACTED] | |
| 17. SIGNATURE OF JURY [REDACTED] | | 18. SIGNATURE OF JURY [REDACTED] | |
| 19. SIGNATURE OF JURY [REDACTED] | | 20. SIGNATURE OF JURY [REDACTED] | |
| 21. SIGNATURE OF JURY [REDACTED] | | 22. SIGNATURE OF JURY [REDACTED] | |
| 23. SIGNATURE OF JURY [REDACTED] | | 24. SIGNATURE OF JURY [REDACTED] | |
| 25. SIGNATURE OF JURY [REDACTED] | | 26. SIGNATURE OF JURY [REDACTED] | |
| 27. SIGNATURE OF JURY [REDACTED] | | 28. SIGNATURE OF JURY [REDACTED] | |
| 29. SIGNATURE OF JURY [REDACTED] | | 30. SIGNATURE OF JURY [REDACTED] | |
| 31. SIGNATURE OF JURY [REDACTED] | | 32. SIGNATURE OF JURY [REDACTED] | |
| 33. SIGNATURE OF JURY [REDACTED] | | 34. SIGNATURE OF JURY [REDACTED] | |
| 35. SIGNATURE OF JURY [REDACTED] | | 36. SIGNATURE OF JURY [REDACTED] | |
| 37. SIGNATURE OF JURY [REDACTED] | | 38. SIGNATURE OF JURY [REDACTED] | |
| 39. SIGNATURE OF JURY [REDACTED] | | 40. SIGNATURE OF JURY [REDACTED] | |
| 41. SIGNATURE OF JURY [REDACTED] | | 42. SIGNATURE OF JURY [REDACTED] | |
| 43. SIGNATURE OF JURY [REDACTED] | | 44. SIGNATURE OF JURY [REDACTED] | |
| 45. SIGNATURE OF JURY [REDACTED] | | 46. SIGNATURE OF JURY [REDACTED] | |
| 47. SIGNATURE OF JURY [REDACTED] | | 48. SIGNATURE OF JURY [REDACTED] | |
| 49. SIGNATURE OF JURY [REDACTED] | | 50. SIGNATURE OF JURY [REDACTED] | |
| 51. SIGNATURE OF JURY [REDACTED] | | 52. SIGNATURE OF JURY [REDACTED] | |
| 53. SIGNATURE OF JURY [REDACTED] | | 54. SIGNATURE OF JURY [REDACTED] | |
| 55. SIGNATURE OF JURY [REDACTED] | | 56. SIGNATURE OF JURY [REDACTED] | |
| 57. SIGNATURE OF JURY [REDACTED] | | 58. SIGNATURE OF JURY [REDACTED] | |
| 59. SIGNATURE OF JURY [REDACTED] | | 60. SIGNATURE OF JURY [REDACTED] | |
| 61. SIGNATURE OF JURY [REDACTED] | | 62. SIGNATURE OF JURY [REDACTED] | |
| 63. SIGNATURE OF JURY [REDACTED] | | 64. SIGNATURE OF JURY [REDACTED] | |
| 65. SIGNATURE OF JURY [REDACTED] | | 66. SIGNATURE OF JURY [REDACTED] | |
| 67. SIGNATURE OF JURY [REDACTED] | | 68. SIGNATURE OF JURY [REDACTED] | |
| 69. SIGNATURE OF JURY [REDACTED] | | 70. SIGNATURE OF JURY [REDACTED] | |
| 71. SIGNATURE OF JURY [REDACTED] | | 72. SIGNATURE OF JURY [REDACTED] | |
| 73. SIGNATURE OF JURY [REDACTED] | | 74. SIGNATURE OF JURY [REDACTED] | |
| 75. SIGNATURE OF JURY [REDACTED] | | 76. SIGNATURE OF JURY [REDACTED] | |
| 77. SIGNATURE OF JURY [REDACTED] | | 78. SIGNATURE OF JURY [REDACTED] | |
| 79. SIGNATURE OF JURY [REDACTED] | | 80. SIGNATURE OF JURY [REDACTED] | |
| 81. SIGNATURE OF JURY [REDACTED] | | 82. SIGNATURE OF JURY [REDACTED] | |
| 83. SIGNATURE OF JURY [REDACTED] | | 84. SIGNATURE OF JURY [REDACTED] | |
| 85. SIGNATURE OF JURY [REDACTED] | | 86. SIGNATURE OF JURY [REDACTED] | |
| 87. SIGNATURE OF JURY [REDACTED] | | 88. SIGNATURE OF JURY [REDACTED] | |
| 89. SIGNATURE OF JURY [REDACTED] | | 90. SIGNATURE OF JURY [REDACTED] | |
| 91. SIGNATURE OF JURY [REDACTED] | | 92. SIGNATURE OF JURY [REDACTED] | |
| 93. SIGNATURE OF JURY [REDACTED] | | 94. SIGNATURE OF JURY [REDACTED] | |
| 95. SIGNATURE OF JURY [REDACTED] | | 96. SIGNATURE OF JURY [REDACTED] | |
| 97. SIGNATURE OF JURY [REDACTED] | | 98. SIGNATURE OF JURY [REDACTED] | |
| 99. SIGNATURE OF JURY [REDACTED] | | 100. SIGNATURE OF JURY [REDACTED] | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. ONLY IF IT IS SIGNED BY A PHYSICIAN OR A JURY OF THE COUNTY OR CITY IN WHICH THE DECEASED RESIDES. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR A JURY OF ANOTHER COUNTY OR CITY.

3730

CERTIFICATE OF DEATH

0371630

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 52 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 N. Beechwood Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MARIAN Middle A. Last CAVILER | | | | 4. DATE OF DEATH Month April Day 2, Year 19 57 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 1, 1870 | 9. AGE (In years last birthday) 86 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | | | 10b. KIND OF BUSINESS OR INDUSTRY Penna. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Joseph Kreamer | | | | 14. MOTHER'S MAIDEN NAME Marian Clark | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mr. Horace M. Caviler, Jr.-905 Stamford Rd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO (c) DISEASE | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 DAYS YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHO PNEUMONIA | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from July , 19 53 , to April 2 , 19 57 , that I last saw the deceased alive on April 1 , 19 57 , and that death occurred at 2 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Melvin N. Borden M.D. 5000 OLD FREDERICK RD | | | | DATE SIGNED 4/3/57 | | | |
| PHYSICIAN'S NAME (Type) Melvin N. BORDEN BALTO 29, MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/5/57 | | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 22d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Baltol 17th | | | | 24a. REC'D BY REGISTRAR DATE 4/5/57 | | 24b. REGISTRAR'S SIGNATURE R. H. Hedusky | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3731 CERTIFICATE OF DEATH

03717

Reg. Dist. No.

| | | | |
|---|---------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE-MD</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24114 ESSEX RD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIDGEWAY MANOR NURS HOME BALTO</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>ROSCINA</u> Last <u>CHAGET</u> | | 4. DATE OF DEATH Month <u>APRIL</u> Day <u>24</u> Year <u>1957</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 3 1878</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOSEPH GREENWALD</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>MRS. GRISTANCE McKELDIN</u> | | Address <u>3504 PLATEAU AVE #7 MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONG. HEART FAILURE & PULMONARY EDEMA</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>HYPERTENSIVE C.V. DISEASE, CHRONIC CONG. HEART FAILURE 5 YRS</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC NEPHRITIS</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>JUNE 1 1953</u> to <u>APRIL 24 1957</u> , that I last saw the deceased alive on <u>APRIL 24 1957</u> and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D. <u>3601 Clymer Rd</u> | | ADDRESS (Street, city or town, state) DATE SIGNED <u>4/24/57</u> | |
| PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>4/27/1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Pikesville Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> ADDRESS <u>Ave.</u> | | 24a. REC'D BY REGISTRAR <u>DATE APR 30 '57</u> | 24b. REGISTRAR'S SIGNATURE <u>Overland</u> |

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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|------------------------|--|----------------------|--|-------------------|--|------------------------|--|-----------------------|--|--------------------------|--|-----------------------|--|---------------------|--|---------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | DATE OF INTERMENT | | PLACE OF INTERMENT | | CITY OF INTERMENT | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | | HISTORY | | FAMILY HISTORY | | SOCIAL HISTORY | | OCCUPATION | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF JURY | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF MINISTER | | SIGNATURE OF CHURCH | | SIGNATURE OF FUNERAL HOME | |

BUREAU V. 3

APR 30 1957

RECEIVED

3732 CERTIFICATE OF DEATH

Reg. Dist. No. 38

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|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b 4 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home | | e. STREET ADDRESS 1221 Dulaney Valley Rd. | |
| 3. NAME OF DECEASED (Type or print) First Carvel Middle Cole Last Cole | | 4. DATE OF DEATH Month 4-28-57 Day 19 Year 19 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-1-1877 |
| 9. AGE (In years last birthday) 80 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner-operator | | 10b. KIND OF BUSINESS OR INDUSTRY tobacco sales | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Craven Cole | | 14. MOTHER'S MAIDEN NAME Eleanor Foster | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Edith B. Cole, | | Address 1221 Dulaney Valley Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gen's Decompensative Cardio Vascular Disease 422.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Dec. 10, 1957 to April 28, 1957 , that I last saw the deceased alive on April 28, 1957 , and that death occurred at 1 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd. Baltimore 12, Md. DATE SIGNED | | | |
| ACTUAL SIGNATURE Laurence C. Post | | M.D. 6805 York Rd. Baltimore 12, Md. | |
| PHYSICIAN'S NAME (Type) LAURENCE C. POST | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-1-57 | 22c. NAME OF CEMETERY OR CREMATORY Forest Baptist | 22d. LOCATION (City, town, or county) (State) Upperco, Balto. Co., Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks | | ADDRESS 622 York Rd., Towson 4, Md. | |
| 24a. REC'D BY REGISTRAR DATE 5/1/57 | | 24b. REGISTRAR'S SIGNATURE Mabel C. Gray | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

MAY 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03719

3733

CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> | | | | c. LENGTH OF STAY IN 1b <u>Life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1213 Fuselage Ave.</u> | | | | d. STREET ADDRESS <u>1213 Fuselage Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Elizabeth R. Compher</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec. 16, 1942</u> | |
| 9. AGE (In years last birthday) <u>14</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>School</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Everett C. Compher</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Sheets</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mrs. Mary E. Sheets</u> Address <u>1213 Fuselage Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>osteogenic CA</u> <u>196X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic to lung</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 YR</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>4-10</u> , 19 <u>57</u> to <u>4-10</u> , 19 <u>57</u> that I last saw the deceased alive on <u>4-10</u> , 19 <u>57</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>Marvin J. Rombro</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Marvin J. Rombro, M.D.</u> <u>805 Fuselage Ave. Balto. Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>April 13, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u> | | 22d. LOCATION (City, town, or county) (State) <u>Belair Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> | | | | ADDRESS <u>7401 Belair Rd.</u> | | 24a. REC'D BY REGISTRAR <u>Edith Hurley</u> | |
| 24b. REGISTRAR'S SIGNATURE | | | | DATE <u>APR 15 1957</u> | | | |

3734

CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|--|----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b <u>5 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u> | | | | d. STREET ADDRESS <u>916 West Baltimore St</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Elizabeth</u> Last <u>COSNER</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 51</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8-26-80</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Months | | Days | | Hours | | Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife-factory worker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u> | | 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Jacob Ours</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>unknown</u> | | 17. INFORMANT Address <u>Records - Spring Grove State Hospital</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>April 17</u> , 19 <u>57</u> , to <u>April 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 22</u> , 19 <u>57</u> , and that death occurred at <u>5:05a</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Stella Wachsler</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>4-22-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u> | | | | <u>Catonsville 28, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4-24-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. Ours</u> ADDRESS <u>127 S Paul St Baltimore, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>APR 24 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Quinn</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF DECEASED | |
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3735 CERTIFICATE OF DEATH

Reg. Dist. No. 03721

Items 9, 13, 14 Film G214 4-24-57 et

| | | | | | | | |
|--|-------------------------------|--|-------------------------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <i>Baltimore</i> | | MARYLAND | | STATE <i>Maryland</i> | | COUNTY <i>Baltimore</i> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Texas</i> | | LENGTH OF STAY (in this place) <i>40 yrs</i> | | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Texas</i> | | TOWN | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Church Lane</i> | | | | STREET ADDRESS (If rural give location) <i>Church Lane</i> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Clinton Webster Croust</i> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <i>April 18 1957</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Color</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>17 May 1885</i> | 9. AGE last birthday <i>71 7/8</i> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Truck Driver</i> | | 11. BIRTHPLACE (State or foreign country) <i>Balto Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216 074575</i> | | 17. INFORMANT & ADDRESS <i>Wife - Same</i> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 4201 IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>Few minutes</i> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Artery Disease</i> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arterio sclerotic cardio-vascular disease</i> | | | | 5 yrs | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>19 May 1957</i> to <i>18 April 1957</i> , that I last saw the deceased alive on <i>17 April 1957</i> , and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Walter J. Rees</i> | | | | DATE SIGNED <i>18 April 1957</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | | | DATE THEREOF <i>APR 21 1957</i> | | NAME OF CEMETERY OR CREMATORY <i>MAY'S CHAPEL CEM.</i> | |
| 24. REC'D BY REGISTRAR <i>APR 25 1957</i> | | | | REGISTRAR'S SIGNATURE <i>H. H. Reusch</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>John Burke, Son, Towson, Md</i> | |

CERTIFICATE OF DEATH

DEATH REPORTED BY

NAME

RELATION TO DECEASED

PLACE OF DEATH

STREET

CITY

STATE

COUNTY

ZIP CODE

DATE OF DEATH

TIME OF DEATH

PLACE OF BIRTH

STREET

CITY

STATE

COUNTY

ZIP CODE

DATE OF BIRTH

TIME OF BIRTH

PLACE OF BIRTH

STREET

CITY

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COUNTY

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DATE OF BIRTH

TIME OF BIRTH

PLACE OF BIRTH

STREET

CITY

STATE

COUNTY

ZIP CODE

IN MEDICAL CERTIFICATION

STATEMENT OF PHYSICIAN

NAME

RELATION TO DECEASED

STREET

CITY

STATE

COUNTY

ZIP CODE

DATE OF BIRTH

TIME OF BIRTH

PLACE OF BIRTH

STREET

CITY

STATE

COUNTY

ZIP CODE

DATE OF BIRTH

BUREAU V. S.

APR 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03722

Reg. Dist. No. 45

3736

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|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River-ro</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3101-4</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bowyer's Pts - Chestnut Road</u> | | d. STREET ADDRESS <u>508 SOUTH DUCAN STREET</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First Middle Last | | 4. DATE OF DEATH <u>4-7-1957</u> Month Day Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 15, 1942</u> |
| 9. AGE (In years last birthday) <u>14</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>PENNA.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>WILLIAM CUPAK</u> | | 14. MOTHER'S MAIDEN NAME <u>BARBARA HENNESSEY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>JOSEPH ZAKENS</u> | | Address <u>508 SOUTH DUCAN STREET</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> 850x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>850x</u> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (See signature of injury in Part I or Part II of item 18.) <u>Row Boat + Boy was unable to swim</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>4-7-1957</u> Hour <u>4:40</u> a.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Middle River</u> | | 20f. (City or town) <u>Middle River</u> (County) <u>Baltimore</u> (State) <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>M B Davis</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>M B Davis M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>4/10/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEMETERY</u> | | 22d. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly & Yeiler Inc.</u> | | 24a. REC'D BY REGISTRAR <u>4/10/57</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Earl Hurley</u> | |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G215 5-17-57 et

3737

CERTIFICATE OF DEATH

03723

Reg. Dist. No.

31

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|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2006 Mosby Ave. | | | d. STREET ADDRESS 2006 Mosby Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) FREDERICK DAHLMANN | | | 4. DATE OF DEATH Month April Day 15 Year 19 57 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 17, 1900 | 9. AGE (In years last birthday) 57 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Maker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Barmen - Germany | |
| 13. FATHER'S NAME Frederick Dahlmann | | | 14. MOTHER'S MAIDEN NAME Clara Zimmermann | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 215-05-6354 | | 17. INFORMANT Marie Dahlmann-2006 Mosby Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 wks. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from 4/12 , 19 57 to 4/15 , 19 57 , that I last saw the deceased alive on 4/12 , 19 57 , and that death occurred at 5 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6410 Windsor Mill Road DATE SIGNED | | | | | |
| ACTUAL SIGNATURE Milton Schlenoff M.D. | | | | | |
| PHYSICIAN'S NAME (Type) MILTON SCHLENOFF, M.D. 6410 Windsor Mill Road | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/18/1957 | | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery | |
| 22d. LOCATION (City, town, or county) Baltimore | | (State) Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost Ave. | | | 24a. REC'D BY REGISTRAR APR 18 1957 | | |
| 24b. REGISTRAR'S SIGNATURE Dr. Wm. Martin | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3738

CERTIFICATE OF DEATH

03724
44

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> | | | | c. LENGTH OF STAY IN 1b <u>26 Days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u> | | | | d. STREET ADDRESS <u>815 Tessier Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>L.</u> Last <u>DANIELS</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Colored</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 19, 1907</u> | |
| 9. AGE (In years last birthday) yrs. <u>49</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Country Club</u> | | 11. BIRTHPLACE (State or foreign country) <u>Jacksonville, Florida</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>Holman Daniels</u> | | 14. MOTHER'S MAIDEN NAME <u>Lillie Baker</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>WW 11</u> | | 17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE UPPER ESOPHAGUS</u> <u>150x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 20g. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>March 9</u> , 19 <u>57</u> , to <u>April 4</u> , 19 <u>57</u> , and that death occurred at <u>2:05 P. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Armen Bogosian</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u> | | | |
| PHYSICIAN'S NAME (Type) <u>ARMEN BOGOSIAN, M.D.</u> | | | | DATE SIGNED <u>4/5/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4-8-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis A. Hensley</u> | | | | 24a. REC'D BY REGISTRAR <u>APR 8 1957</u> | | | |
| ADDRESS <u>Hensley Funeral Service, 578 W. Biddle Str Balto</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Armen L. L. L.</u> | | | |
| | | | | Maryland | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|-----------------|--|---------------|--|----------------|--|-------------------|--|---------------------|--|---------------------|--|---------------------|--|---------------------|--|---------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| JAMES H. HARRIS | | Male | | 45 | | May 10, 1907 | | Maryland | | Baltimore, Maryland | | Heart Disease | | May 10, 1957 | | 10:00 AM | | Home | | J. H. Harris | | J. H. Harris | |
| Occupation | | Married | | Single | | Widowed | | Divorced | | Never Married | | Previous Illnesses | | Previous Operations | | Previous Accidents | | Previous Habits | | Previous Occupations | | Previous Residences | |
| None | | Yes | | No | | No | | No | | No | | None | | None | | None | | None | | None | | None | |
| Education | | Schooling | | Literacy | | Religion | | Race | | Color | | Height | | Weight | | Build | | Complexion | | Hair | | Eyes | |
| High School | | 8 | | Yes | | Catholic | | White | | White | | 5' 10" | | 170 | | Medium | | Fair | | Brown | | Blue | |
| Married | | Yes | | No | | No | | No | | No | | No | | No | | No | | No | | No | | No | |
| Date of Marriage | | Date of Divorce | | Date of Death | | Date of Burial | | Date of Interment | | Date of Cremation | | Date of Disposition | | Date of Disposition | | Date of Disposition | | Date of Disposition | | Date of Disposition | | Date of Disposition | |
| None | | None | | None | | None | | None | | None | | None | | None | | None | | None | | None | | None | |

BUREAU V. S.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3739

CERTIFICATE OF DEATH

Reg. Dist. No.

037253

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Rosewood State Training School</u> <u>Owings Mills, Md. Balto. Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md.</u> c. LENGTH OF STAY IN 1b <u>2 yr. 10 mo.</u> | | | | 1. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3914 Wabash Avenue</u> d. STREET ADDRESS <u>Baltimore 15, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Rudolph</u> Last <u>Davis</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>29th</u> Year <u>19 57</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Norman Bernard Davis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Evelyn Esther Jaffa</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>Rosewood Records</u> | | 17. INFORMANT <u>Rosewood Records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Familial amaurosis (Tay Sachs' disease)</u> <u>3255</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>since birth</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 9,</u> 19 <u>54</u> , to <u>April 29,</u> 19 <u>57</u> , that I last saw the deceased alive on <u>April 29</u> 19 <u>57</u> , and that death occurred at <u>2:52 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Harry G. Butler</u> | | M.D. <u>Owings Mills, Md.</u> | | ADDRESS (Street, city or town, state) | | DATE SIGNED <u>4/29/57</u> | |
| PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M. D.</u> | | <u>Rosewood St. Tr. School</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4-30-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc.</u> | | | | ADDRESS <u>2100 E. Tow PL</u> | | 24. REC'D BY REGISTRAR <u>MAY 1 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Mary Elise</u> | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|-------------|--|---------------|--|---------------|--|----------------|--|-----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1928 | | MOBILE, ALABAMA | |
| MARRIAGE | | DATE | | PLACE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MARRIED | | 1950 | | BALTIMORE, MD | | MAY 1, 1968 | | BALTIMORE, MD | | HEART DISEASE | |
| OCCUPATION | | DATE | | PLACE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| CONGRESSMAN | | 1960 | | BALTIMORE, MD | | MAY 1, 1968 | | BALTIMORE, MD | | HEART DISEASE | |
| EDUCATION | | DATE | | PLACE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| HIGH SCHOOL | | 1945 | | BALTIMORE, MD | | MAY 1, 1968 | | BALTIMORE, MD | | HEART DISEASE | |
| RELIGION | | DATE | | PLACE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| METHODIST | | 1945 | | BALTIMORE, MD | | MAY 1, 1968 | | BALTIMORE, MD | | HEART DISEASE | |
| MANNER OF DEATH | | DATE | | PLACE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| NATURAL | | 1968 | | BALTIMORE, MD | | MAY 1, 1968 | | BALTIMORE, MD | | HEART DISEASE | |
| DATE OF DEATH | | DATE | | PLACE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| MAY 1, 1968 | | MAY 1, 1968 | | BALTIMORE, MD | | MAY 1, 1968 | | BALTIMORE, MD | | HEART DISEASE | |
| PLACE OF DEATH | | DATE | | PLACE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| BALTIMORE, MD | | MAY 1, 1968 | | BALTIMORE, MD | | MAY 1, 1968 | | BALTIMORE, MD | | HEART DISEASE | |
| CAUSE OF DEATH | | DATE | | PLACE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| HEART DISEASE | | MAY 1, 1968 | | BALTIMORE, MD | | MAY 1, 1968 | | BALTIMORE, MD | | HEART DISEASE | |
| MANNER OF DEATH | | DATE | | PLACE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| NATURAL | | MAY 1, 1968 | | BALTIMORE, MD | | MAY 1, 1968 | | BALTIMORE, MD | | HEART DISEASE | |

BUREAU V. 1

MAY 1 1968

RECEIVED

3698

CERTIFICATE OF DEATH

03726

Reg. Dist. No.

4✓

| | | | | | | | |
|--|--|----------------------|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Life</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crofton 51</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1250 Sulphur Spring Rd.</u> | | | | d. STREET ADDRESS <u>1250 Sulphur Spring Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>VERDINAND DEBOY</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 4. DATE OF DEATH First <u>4</u> Middle <u>DEBOY</u> Last <u>11</u> Year <u>1957</u> | | | | 5. SEX <u>Male</u> | | | |
| 6. COLOR OR RACE <u>White</u> | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH <u>Aug 1881</u> | | | | 9. AGE (In years last birthday) <u>75</u> yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | |
| 13. FATHER'S NAME <u>Verdinand De Boy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Beitz</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>1250 Sulphur Spring Rd.</u> | | | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260</u> (b) <u>Arteriosclerotic CVD</u> DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>Nov.</u> 1955, to <u>Apr 11</u> 1957, that I last saw the deceased alive on <u>Apr 9</u> 1957, and that death occurred at <u>9:50</u> A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Herbert J. Levickas</u> M.D. <u>5305 East Drive</u> | | | | ADDRESS (Street, city or town, state) <u>Baltimore - 27, Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u> | | | | DATE SIGNED <u>4/13/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>April 15 1957</u> | | <u>New Cathedral Cem</u> | | <u>Federick St. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Gertrude Perry</u> | | | | ADDRESS <u>5046 Connelley</u> | | | |
| 24a. REC'D BY REGISTRAR <u>APR 17 1957</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Dr. John Huffer</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 17 1957

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3740

CERTIFICATE OF DEATH

Reg. Dist. No.

03727

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE | | | | c. LENGTH OF STAY IN 1b 4 WEEKS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MT. WILSON STATE HOSPITAL | | | | d. STREET ADDRESS BOX 287 | | | |
| 3. NAME OF DECEASED (Type or print) First MICHAEL Middle JEMBECK Last JEMBECK | | | | 4. DATE OF DEATH Month APRIL Day 29 Year 1957 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2 1901 | |
| 9. AGE (In years last birthday) 56 yrs. | | IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | | | 10b. KIND OF BUSINESS OR INDUSTRY FARMING | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME AUGUST JEMBECK | | | | 14. MOTHER'S MAIDEN NAME ANNIE BECKING | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNGS 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 Months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA OF LEFT PLEURA. | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-1- , 19 57 , to 4-29- , 19 57 , that I last saw the deceased alive on 4-29- , 19 57 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED ACTUAL SIGNATURE William Newcomer M.D. PHYSICIAN'S NAME (Type) WILLIAM NEWCOMER, M. D., SUPERINTENDENT | | | | | | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | May 2-57 | | Mount Hope of Md | | German Hill Rd B & Co Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bernard G Funk | | | | ADDRESS 12500 Greenway Rd | | 24a. REC'D BY REGISTRAR 1957 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Dorothy Newell | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 2 1957

BUREAU V. S.

EMPHYSEMA OF LEFT PLEURA.

CARCINOMA OF LUNGS

None

AGUST DENBECK

ANNIE BENNING

FARMER

MARYLAND

MARY WHITE

POI

MICHAEL

DENBECK

APRIL 20 1957

MILVICH STATE HOSPITAL

Box 287

SEVERN, MD.

BALTIMORE

MARYLAND

ANNE ARUNDEL

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

3741

CERTIFICATE OF DEATH

Reg. Dist. No.

31

| | | | | | | | |
|---|---------------------------|---|-------------------------------------|--|-----------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CYVON OAK</u> | | | | c. LENGTH OF STAY IN 1b <u>4 yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGSBURG HOME</u> | | | | e. STREET ADDRESS <u>1020 E 36th St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Margaret</u> First Middle Last | | | | 4. DATE OF DEATH <u>April 28 1957</u> Month Day Year | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 1, 1875</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Charles</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Records Augsburg Home</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arterio - Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arterio - Sclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct. 24 - 1952</u> , to <u>April 28, 1957</u> , that I last saw the deceased alive on <u>April 25, 1957</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Earl L. Chambers</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>4108 Liberty Hts. Balto. Md</u> | | | |
| DATE SIGNED <u>4-29-57</u> | | | | DATE SIGNED <u>4-29-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u> | | | | ADDRESS <u>4108 Liberty Hts. Balto. Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>May 1, 57</u> | | <u>Fordham</u> | | <u>Balto Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Heermann</u> ADDRESS <u>6067 Hayford Rd</u> | | | | 24a. REC'D BY REGISTRAR <u>MAY 1 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Paul Heermann</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

MAY 1 1957

RECEIVED

3742

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|-------------------------------|--|--------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home | | | | d. STREET ADDRESS 327 Stratford Road-Balto. 28, Md. | | | |
| 3. NAME OF DECEASED (Type or print) THORNTON First Middle Last DORSEY | | | | 4. DATE OF DEATH Month April Day 26 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 1, 1886 | 9. AGE (In years last birthday) 70 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Agent | | | | 10b. KIND OF BUSINESS OR INDUSTRY American Railway Express | | 11. BIRTHPLACE (State or foreign country) Calvert County, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Benjamin Dorsey | | | | 14. MOTHER'S MAIDEN NAME Eliza Wilson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Yes | | 17. INFORMANT Address Mrs. Catherine B. Dorsey-327 Stratford Road #28 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from 10/17, 1949 to 4/26, 1957 , that I last saw the deceased alive on 4/26, 1957 , and that death occurred at 8 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Robert A. Reiter M.D. 3406 Windsor Ave. | | | | ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 4/27/57 | | | |
| PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D. Baltimore - 16, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/29/57 | | 22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - North & Re. ADDRESS _____ | | | | 24a. REC'D BY REGISTRAR DATE APR 30 '57 | | 24b. REGISTRAR'S SIGNATURE Qu... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2007/08/24

BUREAU V. S.

MAY 1 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03730

374 **CERTIFICATE OF DEATH**

Reg. Dist. No. 38

STELLA Maris Hospice

| | | | | | | | |
|--|---|---|--|--|---------------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Baltimore | | STATE Maryland | | COUNTY | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) Rural - Towson | | LENGTH OF STAY (in this place) App. 1 Yr. | | CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore | | 3701-1 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Stella Maris Hospice | | | | STREET ADDRESS (If rural give location) 3959 Greenmount Ave. | | | |
| 3. NAME OF DECEASED (Type or Print) William A. DOUGHERTY | | | | 4. DATE OF DEATH (Month) (Day) (Year) April 8 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH May 1873 | 9. AGE last birthday 83 yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Ret. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Dennis Dougherty | | | | 14. MOTHER'S MAIDEN NAME Mary Callahan | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. Yes | | 17. INFORMANT & ADDRESS Apt. 12 Mrs. Katherin Roche-426 Winston Ave. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 442X IMMEDIATE CAUSE (A) Cerebral Hemorrhage | | | | INTERVAL BETWEEN ONSET AND DEATH 4 Days | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Cardio Renal | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Vascular Disease | | | | 20 years | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from March 1956, to April 8, 1957, that I last saw the deceased alive on April 2, 1957, and that death occurred at 11:17 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Charlotte Tronell</i> | | | | ADDRESS (Street, city, town, state) 7501 York Rd. Baltimore, Md. | | DATE SIGNED 4/4/57 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEROF 4/12/57 | | NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. REC'D BY REGISTRAR DATE APR 11 1957 | | REGISTRAR'S SIGNATURE <i>Mabel Gray</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE John A. Moran-3000 E. Baltimore Street | | | |

108750

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Form No. 10

1. LEGAL REPRESENTATIVE (Name of Person)

NAME: Maryland
RESIDENCE: Baltimore

NAME: Maryland
RESIDENCE: Baltimore

NAME: Maryland
RESIDENCE: Baltimore

3559 Greenmount Ave.

Stella E. the Hospice

83

May 1873

White

White

Male

Baltimore, Maryland

Ref.

St. James

Mr. T. G. Gorman

Dennis Doherty

Apr. 12

Mrs. Katharine Boone-Joe Simpson Ave.

Yes

No

BUREAU M.D.

APR 11 1957

RECEIVED

St. Catherine's Cemetery

4/11/57

Buried

John A. Moran-3000 E. Baltimore Street

03731

3741 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 CATONSVILLE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOMINICAN CONVENT | | d. STREET ADDRESS 720 MAIDEN CHOICE LANE | |
| 3. NAME OF DECEASED (Type or print) First Middle Last SR. M. VINCENT FERRER DUGGAN | | 4. DATE OF DEATH Month Day Year APR 15, 1957 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOV. 2, 1892 |
| 9. AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NUN | | 10b. KIND OF BUSINESS OR INDUSTRY DOMINICAN | 11. BIRTHPLACE (State or foreign country) ENGELWOOD, N. J. |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME PATRICK WALLACE DUGGAN | |
| 14. MOTHER'S MAIDEN NAME ELLEN CULLEN | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Address SR. MARY JESUS SAME | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic CV disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Childhood | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 3/12 , 19 57 , to 4/15 , 19 57 , that I last saw the deceased alive on 4/15 , 19 57 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Walter F. King M.D. | | ADDRESS (Street, city or town, state) Catonville, Md. DATE SIGNED 4/16/57 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 4-17-57 | 22c. NAME OF CEMETERY OR CREMATORY CONVENT CEM. | 22d. LOCATION (City, town, or county) (State) 720 MAIDEN CHOICE LANE, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zuber | | 24a. REC'D BY REGISTRAR 9013 CONKLING ST. BALTO., 24 MD. | 24b. REGISTRAR'S SIGNATURE R. H. Hedrick |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 22 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03732

3745 **CERTIFICATE OF DEATH**

Reg. Dist. No. 40

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | STATE <u>Maryland</u> COUNTY <u>Baltimore</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Long Green</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Long Green</u> | |
| TOWN <u>Long Green</u> | | LENGTH OF STAY (in this place) <u>14 yrs.</u> | | TOWN <u>Long Green</u> | | STREET ADDRESS (If rural give location) <u>Manor Rd.</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Manor Rd.</u> | | | | STREET ADDRESS (If rural give location) <u>Manor Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Albert M Dunkes</u> | | | | 4. DATE OF DEATH <u>April 4 1957</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | | 8. DATE OF BIRTH <u>August 7, 1900</u> | |
| 9. AGE last birthday <u>56</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Newport News, Va.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>Frank Dunkes</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Elizabeth Lentz</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT & ADDRESS <u>Dora E. Dunkes Manor Rd. Glenarm, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 180X IMMEDIATE CAUSE (A) <u>Carcinomatosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>metastasis from Hypernephroma</u> | | | | | | <u>5 mo.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>5-21</u> , 19 <u>56</u> , to <u>4-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-3</u> , 19 <u>57</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>William A. Tyson</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>4-4-57</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>April 7, 1957</u> | | NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u> | | LOCATION (City, town, or county) (State) <u>Fork, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Dr. Walter H. Smith</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Lozano Funeral Home</u> | | ADDRESS <u>7401 Belair Rd.</u> | |
| DATE <u>APR 8 1957</u> | | | | | | | |

INSTRUCTIONS

1. This is a summary of the information furnished by the informant, and is not to be used as a basis for the investigation. It is to be used only for the purpose of identifying the person or persons who may be connected with the case.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Form 100-100

IN CASE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

BUREAU V. 3

APR 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Item 18 Film 214 4-28-57

4-28-57
3746
MAY 1 1957
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03733

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 8mth20dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First James Middle Henry Last Ebling, Sr. | | 4. DATE OF DEATH Month April Day 21 Year 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Oct. 17, 1884 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baker | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Henry Ebling | | 14. MOTHER'S MAIDEN NAME Anna Haymes | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombosis & infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio vascular disease DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Geo M Kieffer | | DATE SIGNED 4-22-57 | |
| EXAMINER'S NAME (Type) George M. Kieffer, M. D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 4-25-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY St Annes | | 22d. LOCATION (City, lawn, or county) (State) Annapolis Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor | | 24a. REC'D BY REGISTRAR 4/23/57 | |
| ADDRESS St Annes | | 24b. REGISTRAR'S SIGNATURE J. J. Trench | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF DEATH: _____
5. TIME OF DEATH: _____
6. PLACE OF DEATH: _____
7. CAUSE OF DEATH: _____
8. MANNER OF DEATH: _____
9. SIGNATURE OF EXAMINER: _____
10. SIGNATURE OF WITNESS: _____
11. SIGNATURE OF CORONER: _____
12. SIGNATURE OF JURY: _____
13. SIGNATURE OF JUDGE: _____
14. SIGNATURE OF CLERK: _____
15. SIGNATURE OF SHERIFF: _____
16. SIGNATURE OF DEPUTY SHERIFF: _____
17. SIGNATURE OF CONSTABLE: _____
18. SIGNATURE OF JAILER: _____
19. SIGNATURE OF PRISONER: _____
20. SIGNATURE OF GUARD: _____
21. SIGNATURE OF WARDEN: _____
22. SIGNATURE OF CHIEF OF POLICE: _____
23. SIGNATURE OF DEPUTY CHIEF OF POLICE: _____
24. SIGNATURE OF SQUAD LEADER: _____
25. SIGNATURE OF OFFICER: _____
26. SIGNATURE OF DETECTIVE: _____
27. SIGNATURE OF INSPECTOR: _____
28. SIGNATURE OF SUPERVISOR: _____
29. SIGNATURE OF ASST. SUPERVISOR: _____
30. SIGNATURE OF CLERK: _____
31. SIGNATURE OF RECEPTIONIST: _____
32. SIGNATURE OF MAIL ROOM: _____
33. SIGNATURE OF TELEPHONE ROOM: _____
34. SIGNATURE OF JANITOR: _____
35. SIGNATURE OF GARDENER: _____
36. SIGNATURE OF COOK: _____
37. SIGNATURE OF BAKER: _____
38. SIGNATURE OF BUTLER: _____
39. SIGNATURE OF HOUSEKEEPER: _____
40. SIGNATURE OF LAUNDRY: _____
41. SIGNATURE OF CLEANING: _____
42. SIGNATURE OF MAINTENANCE: _____
43. SIGNATURE OF SECURITY: _____
44. SIGNATURE OF TRANSPORT: _____
45. SIGNATURE OF STORAGE: _____
46. SIGNATURE OF OFFICE: _____
47. SIGNATURE OF LABORATORY: _____
48. SIGNATURE OF RADIOLOGY: _____
49. SIGNATURE OF PATHOLOGY: _____
50. SIGNATURE OF ANATOMY: _____
51. SIGNATURE OF PHYSIOLOGY: _____
52. SIGNATURE OF BIOLOGY: _____
53. SIGNATURE OF CHEMISTRY: _____
54. SIGNATURE OF METALLURGY: _____
55. SIGNATURE OF MINERALOGY: _____
56. SIGNATURE OF BOTANY: _____
57. SIGNATURE OF ZOOLOGY: _____
58. SIGNATURE OF AGRICULTURE: _____
59. SIGNATURE OF FISHERY: _____
60. SIGNATURE OF FORESTRY: _____
61. SIGNATURE OF MINING: _____
62. SIGNATURE OF MANUFACTURING: _____
63. SIGNATURE OF TRANSPORTATION: _____
64. SIGNATURE OF COMMUNICATIONS: _____
65. SIGNATURE OF PUBLIC UTILITIES: _____
66. SIGNATURE OF EDUCATION: _____
67. SIGNATURE OF HEALTH: _____
68. SIGNATURE OF SOCIAL WELFARE: _____
69. SIGNATURE OF RECREATION: _____
70. SIGNATURE OF CULTURE: _____
71. SIGNATURE OF ARTS: _____
72. SIGNATURE OF LITERATURE: _____
73. SIGNATURE OF MUSIC: _____
74. SIGNATURE OF THEATRE: _____
75. SIGNATURE OF FILM: _____
76. SIGNATURE OF RADIO: _____
77. SIGNATURE OF TELEVISION: _____
78. SIGNATURE OF COMICS: _____
79. SIGNATURE OF GAMES: _____
80. SIGNATURE OF SPORTS: _____
81. SIGNATURE OF RELIGION: _____
82. SIGNATURE OF PHILOSOPHY: _____
83. SIGNATURE OF SCIENCE: _____
84. SIGNATURE OF HISTORY: _____
85. SIGNATURE OF GEOGRAPHY: _____
86. SIGNATURE OF POLITICAL SCIENCE: _____
87. SIGNATURE OF ECONOMICS: _____
88. SIGNATURE OF LAW: _____
89. SIGNATURE OF MEDICINE: _____
90. SIGNATURE OF NURSING: _____
91. SIGNATURE OF DENTISTRY: _____
92. SIGNATURE OF VETERINARY MEDICINE: _____
93. SIGNATURE OF AGRICULTURAL MECHANICS: _____
94. SIGNATURE OF INDUSTRIAL MECHANICS: _____
95. SIGNATURE OF MARINE ENGINEERING: _____
96. SIGNATURE OF AERIAL ENGINEERING: _____
97. SIGNATURE OF ELECTRICAL ENGINEERING: _____
98. SIGNATURE OF MECHANICAL ENGINEERING: _____
99. SIGNATURE OF CIVIL ENGINEERING: _____
100. SIGNATURE OF ARCHITECTURE: _____

BUREAU V. 2

APR 24 1957

RECEIVED

3747

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE c. LENGTH OF STAY IN 1b X2 LUTHERVILLE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION YORK ROAD | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 LUTHERVILLE d. STREET ADDRESS YORK ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) WILLIAM HENRY ECKERS First Middle Last | | | | 4. DATE OF DEATH APRIL 25, 1957 Month Day Year | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JULY 7, 1886 | |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER | | | | 10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME WILLIAM HENRY ECKERS | | | | 14. MOTHER'S MAIDEN NAME BETTY JUSTICE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT MRS. ARDELIA ECKERS Address LUTHERVILLE, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Alcoholism, Acute INTERVAL BETWEEN ONSET AND DEATH 24 hr Weeks Weeks | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 9-4 , 19 56 , to 4/25 , 19 57 , that I last saw the deceased alive on March 9 , 19 57 , and that death occurred at 3:00 P. M, from the causes and on the date stated above. ADDRESS (Street, City or town, state) DATE SIGNED Bennett A. Stoen, M.D. Lutherville, Md 4/26/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Consulted medical examiner. BENNETT A. STOEN, M. D. LUTHERVILLE, MD. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF APRIL 27, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY | | 22d. LOCATION (City, town, or county) (State) PARKVILLE, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons Sons 4747 | | | | 24a. REC'D BY REGISTRAR APR 30 57 | | 24b. REGISTRAR'S SIGNATURE W. J. Smith | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH BALTIMORE 18

1957

BUREAU V. S.

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03735

Item 18 Film 213 4-8-57

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 7mths29dys | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | e. STREET ADDRESS 5529 Cadillac Rd. | | | |
| 3. NAME OF DECEASED (Type or print) First Rose Middle Liven Last Eisenstadt | | | | 4. DATE OF DEATH Month April Day 2 Year 1957 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 12, 1905 | |
| 9. AGE (In years last birthday) 51 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME Myre Liven | | | | 14. MOTHER'S MAIDEN NAME Sara ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pending DUE TO Left Coronary arterio occlusion (c) Presinile disease alzheimers | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE George M. Kieffer M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) George M. KIEFFER, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 4-4-57 | | 22c. NAME OF CEMETERY OR CREMATORY Rosedale | | 22d. LOCATION (City, town, or county) (State) Balto Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewin | | | | ADDRESS 2100 Eutaw Place | | 24a. REC'D BY REGISTRAR DATE 4-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Quinn | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--|--|-------------------------------|--|-----------------------------|--|
| NAME OF DECEASED _____ | | SEX _____ | | AGE _____ | |
| DATE OF DEATH _____ | | TIME OF DEATH _____ | | PLACE OF DEATH _____ | |
| CITY OF DEATH _____ | | COUNTY OF DEATH _____ | | STATE OF DEATH _____ | |
| OCCUPATION _____ | | CAUSE OF DEATH _____ | | MANNER OF DEATH _____ | |
| SIGNATURE OF MEDICAL EXAMINER _____ | | SIGNATURE OF CORONER _____ | | SIGNATURE OF JURY _____ | |
| DATE OF SIGNATURE _____ | | TIME OF SIGNATURE _____ | | PLACE OF SIGNATURE _____ | |

BUREAU N. S.

APR 2 1957

RECEIVED

3749 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | | | c. LENGTH OF STAY IN 1b 26 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS 3801 Frederick Avenue | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last FRANK W. FARINHOLT | | | | 4. DATE OF DEATH Month Day Year April 14 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 23, 1890 | | 9. AGE (In years last birthday) yrs. 66 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Cemetery maintenance | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William H. Farinholt | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Fach | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. WW I 218-03-7465 | | | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS, PULMONARY ARTERY 463X DUE TO PHLEBOTROMBOSIS, LEFT FEMORAL VEIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 3 DAYS | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Bilateral hydronephrosis. 2. Hypertensive cardiovascular disease. 3. Benign prostatic hypertrophy. 4. Abscess, right prostatic lobe. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from March 19, 1957 , to April 14, 1957 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Armen Bogosian M.D. VAH, FORT HOWARD, MARYLAND 4/15/57 | | | | | | | |
| ACTUAL SIGNATURE Armen Bogosian M.D. VAH, FORT HOWARD, MARYLAND 4/15/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M.D. VA HOSPITAL, FT. HOWARD, MARYLAND | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-17-57 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Th, Md. | | | | 24a. REC'D BY REGISTRAR APR 17 1957 | | 24b. REGISTRAR'S SIGNATURE Saward L. Farber | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|----------------------|--|------------------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES W. ... | | Male | | ... | | ... | | ... | | ... | | ... | | ... | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | CITY | | STATE | | COUNTRY | |
| ... | | ... | | ... | | ... | | ... | | ... | | ... | | ... | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | CITY | | STATE | | COUNTRY | | ... | |
| ... | | ... | | ... | | ... | | ... | | ... | | ... | | ... | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | | SIGNATURE OF DEATH REGISTRAR | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| ... | | ... | | ... | | ... | | ... | | ... | | ... | | ... | |

RECEIVED
 APR 17 1957
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03737

3750

CERTIFICATE OF DEATH

Reg. Dist. No. 22

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jaymar University Park</u> | | | | c. LENGTH OF STAY IN 1b <u>x 2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6612 Marrott Drive</u> | | | | d. STREET ADDRESS <u>6612 Marrott Drive</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>SOPHIA</u> First Middle Last <u>- FELDMAN</u> | | | | 4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) <u>53</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Abraham Kameron</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mollie</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Oscar Feldman - Same</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senescent carcinoma of the</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of sigmoid</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u> <u>4 years</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>7/11</u> , 19 <u>53</u> , to <u>4/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/12</u> , 19 <u>57</u> , and that death occurred at <u>1205 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2320 Entaw Place</u> DATE SIGNED _____ | | | | | | | |
| ACTUAL SIGNATURE <u>J. J. Zinberg</u> M.D. | | | | 22. FUNERAL DIRECTOR'S SIGNATURE <u>DR. J. J. ZINBERG</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4-24-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Men</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Entaw Place</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>4/25/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Norman E. Martin</u> | |

BUREAU V. 3

APR 25 1957

RECEIVED
APR 26 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03738
41

3688

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK AVENUE | | | | c. LENGTH OF STAY IN 1b 8 YRS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8229 DUNDALK AVENUE | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JOHN CHARLES FINCK JR. | | | | 4. DATE OF DEATH Month APRIL Day 29 Year 1957 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 22, 1904 | | 9. AGE (In years last birthday) 53 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REP. A.F. & L. UNION | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND | | |
| 13. FATHER'S NAME JOHN C. FINCK SR. | | | 12. CITIZEN OF WHAT COUNTRY? USA. | | | | |
| 14. MOTHER'S MAIDEN NAME EDNA UNKNOWN | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT 8229 DUNDALK AVENUE MRS. LILLIAN C. FINCK | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 months | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from Aug 50 , 19 50 , to Apr 57 , 19 57 , that I last saw the deceased alive on 29 Apr , 19 57 , and that death occurred at 9 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. H. MORRISON | | | M.D. 3 Kingship Rd Dundalk 22 Md | | | | |
| PHYSICIAN'S NAME (Type) W. H. MORRISON | | | DATE SIGNED 30 Apr 1957 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5/3/57 | | 22c. NAME OF CEMETERY OR CREMATORY MEADOWBRIDGE MEMORIAL PARK | | | |
| 22d. LOCATION (City, town, or county) (State) BALTIMORE COUNTY | | 23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD. | | | | | |
| 24a. REC'D BY REGISTRAR 1957 | | 24b. REGISTRAR'S SIGNATURE Wm. Kelly | | | | | |

MAY 2 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03739**

3751

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|------------------|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Balto. Howard | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1yr6mths29dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg, Md. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS Glenelg, Howard Co., Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Cecelia Middle Zink Last Fink | | | | 4. DATE OF DEATH Month April Day 14 Year 19 57 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 10, 1897 | 9. AGE (In years last birthday) 59 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY housework | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Zink | | | | 14. MOTHER'S MAIDEN NAME Harriett Watts | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. un known | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 605x Memoria due to Bilateral Pyelonephritis DUE TO (b) due to Urinary Cystitis DUE TO (c) fracture of femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? 904.7 Pickers Disease Presumed Psychosis YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3-8-57 revealed a fractured right femur. Unknown how this fracture occurred. | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 3-1 1957 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital | | 20f. (City or town) (County) (State) Catonsville 28, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Geo M. Kieffer | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED April 14, 57 | |
| EXAMINER'S NAME (Type) George M. Kieffer, M. D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 17 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | | 22d. LOCATION (City, town, or county) (State) Dorsey, Howard Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Lamorean | | | | ADDRESS 4510 Liberty Heights Avenue | | 24a. REC'D BY REGISTRAR APR 17 '57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. J. Smith | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 17 1957

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [REDACTED]
AGE: [REDACTED] SEX: [REDACTED]
DATE OF BIRTH: [REDACTED]
PLACE OF BIRTH: [REDACTED]
DATE OF DEATH: [REDACTED]
PLACE OF DEATH: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]
SIGNATURE OF MEDICAL EXAMINER: [REDACTED]
DATE: [REDACTED]

3752

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Overlea</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Mr. John Fousek</u> | | 4. DATE OF DEATH <u>April 11th</u> 19 <u>57</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 28, 1881</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Watchman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Prov. Sav. Bank Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Frank Fousek</u> | | 14. MOTHER'S MAIDEN NAME <u>Barbara Patrick</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>213 034962A</u> | |
| 17. INFORMANT <u>Mr. Jack L. Fousek, 17 Egges Lane</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>lying cause lost.</u> (c) <u>lying cause lost.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 8</u> , 19 <u>57</u> , to <u>April 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>57</u> , and that death occurred at <u>2:35 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Leo J. Gaver</u> | | ADDRESS (Street, city or town, state) <u>1 Mallow Hill Ave., Baltimore, Md</u> | |
| PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u> | | DATE SIGNED <u>4/11/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 22b. DATE THEREOF <u>4/15/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc</u> | | ADDRESS <u>5305 Harford Rd.</u> | |
| 24a. REC'D BY REGISTRAR <u>APR 16 '57</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

| | | | | | | | | | |
|----------------------------|--|--------------------------|--|--------------------------|--|-----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | |
| 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | |
| 11. MEDICAL HISTORY | | 12. PRESENT ILLNESS | | 13. TREATMENT | | 14. POST-MORTEM EXAMINATION | | 15. SIGNATURE OF PHYSICIAN | |
| 16. SIGNATURE OF REGISTRAR | | 17. SIGNATURE OF WITNESS | | 18. SIGNATURE OF CORONER | | 19. SIGNATURE OF JURY | | 20. SIGNATURE OF JUDGE | |

BUREAU V. S.

APR 16 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6148 Regent Park Rd. | | d. STREET ADDRESS 6148 Regent Park Rd. | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle M. Last France | | 4. DATE OF DEATH Month April Day 29 Year 1957 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 21, 1881 |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY O.H. | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Eckels | | 14. MOTHER'S MAIDEN NAME Elizabeth | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr. William H. France, 6148 Regent Park Rd. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Coronary Artery Disease DUE TO (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 3 hrs 2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1957 to April 29, 1957 , that I last saw the deceased alive on April 29, 1957 and that death occurred at 6:50 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. Nelson McKey | | M.D. 6014 Edmondson Ave Balto DATE SIGNED 29 May 1957 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 1/57 | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | 22d. LOCATION (City, town, or county) (State) Balto. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave. | | 24a. REC'D BY REGISTRAR MAY 6 '57 | |
| 24b. REGISTRAR'S SIGNATURE W. Beach | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G214 4-17-57 et
3689

CERTIFICATE OF DEATH

Reg. Dist. No.

03742
41

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Shore Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Ida First Frankowiak Middle (Franklin) Last | | 4. DATE OF DEATH April 10 1957 19 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sep. 15 1915 |
| 9. AGE (In years last birthday) 42 yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Louis Bialozynski | | 14. MOTHER'S MAIDEN NAME Antonina Hoffman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Adam Franklin | | Address 15 Shore Road | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CV DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 1 HR YEARS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 5 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4 APRIL, 1957 , to 10 APRIL, 1957 , that I last saw the deceased alive on 4 APRIL, 1957 , and that death occurred at 5:30 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. E. Baermann M.D. | | ADDRESS (Street, city or town, state) DR. W. E. BAERMANN 83 DUNDALK AVENUE DUNDALK 22, MARYLAND | |
| DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4/13/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM. | | 22d. LOCATION (City, town, or county) (State) DUNDALK MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Maher | | ADDRESS 4015 Chester St. | |
| 24a. REC'D BY REGISTRAR 4/12/57 | | 24b. REGISTRAR'S SIGNATURE Tom Kelly | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3699

Item 7 FilmG215 5-17-57 et.

Reg. Dist. No.

03742

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u> | | c. LENGTH OF STAY IN 1b <u>57</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>600 Gun Road</u> | | d. STREET ADDRESS <u>600 Gun Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph H. Fuchs</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 23, 1902</u> |
| 9. AGE (In years last birthday) <u>54</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales man</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Sears Robuck Co.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Henry Fuchs</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna V. Talbott</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>W. W. 11</u> | |
| 17. INFORMANT <u>Anna V. Fuchs</u> | | Address <u>5710 Main St. Elkridge</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> | | DATE SIGNED <u>April 10, 57</u> | |
| EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M. D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/15/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> | | ADDRESS <u>4107 Wilkins Ave. Balto Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>APR 15 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Dr. Geo S. M. Kieffer</u> | |

MISSOURI STATE DEPARTMENT OF HEALTH - BULLETIN 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------------|--|--------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF MEDICAL EXAMINER | | 17. SIGNATURE OF JURY | | 18. SIGNATURE OF JURY | |
| 19. SIGNATURE OF JURY | | 20. SIGNATURE OF JURY | | 21. SIGNATURE OF JURY | |
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| 100. SIGNATURE OF JURY | | 101. SIGNATURE OF JURY | | 102. SIGNATURE OF JURY | |

RECEIVED
APR 15 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03744

Reg. Dist. No. 44

3751

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard | | c. LENGTH OF STAY IN 1b 13 Hrs. 20 M. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First, MILTON (Samuel) Middle, S. Last, FULDA | | 4. DATE OF DEATH Month April Day 22 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 1, 1896 |
| 9. AGE (In years last birthday) 61 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Charles Fulda | | 14. MOTHER'S MAIDEN NAME Christina Fitch (also Fetsch) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. 212-09-5155 | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 13 HOURS UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 21 6:05 PM , to April 22 7:25 AM , and that death occurred at 7:25 A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Irving Freeman M.D. | | DATE SIGNED 4/22/57 | |
| PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service VAH, FT. HOWARD, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/25/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, Inc., North & Pennsa. Ave. Balto. | | 24b. REGISTRAR'S SIGNATURE Dr. Dawson Parker | |
| 24a. REC'D BY REGISTRAR DATE 4/25/57 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAINTAINING STATE DEPARTMENT OF HEALTH - BALTIMORE 10

APR 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

037454

3755

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 13½ hrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last GARDNER | | 4. DATE OF DEATH Month April Day 19 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 10/7/17 |
| 9. AGE (In years last birthday) 39 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 11. BIRTHPLACE (State or foreign country) Chestertown, Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Harry Gardner | |
| 14. MOTHER'S MAIDEN NAME Mary Elizabeth Gibson | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII | |
| 16. SOCIAL SECURITY NO. 214-12-5233 | | 17. INFORMANT Address Clin. Rec.Vets.Admin.Hospital, Ft.Howard, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIRRHOSIS OF LIVER DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 1 WEEK FEW YEARS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 12:15 AM to 1:45 PM on April 19 , 19 57 , and that death occurred at 1:45 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Chien Wei Ian | | M.D. Veterans Administration Hospital ADDRESS (Street, city or town, state) DATE SIGNED 4/20/57 | |
| PERSON'S NAME (Type) CHIEN WEI IAN, M. D. | | Fort Howard, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4/23/57 | 22c. NAME OF CEMETERY OR CREMATORY Chestertown Cemetery | 22d. LOCATION (City, town, or county) (State) Chestertown, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Mervin V. Williams | | 24a. REC'D BY REGISTRAR APR 23 1957 24b. REGISTRAR'S SIGNATURE L. Furlong | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3756

CERTIFICATE OF DEATH

03746

Reg. Dist. No.

32

| | | | |
|--|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> <u>MT. WILSON</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b <u>24 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>MT. WILSON STATE HOSPITAL</u> | | d. STREET ADDRESS <u>20x0 2</u> | |
| 3. NAME OF DECEASED (Type or print) <u>LULA</u> First <u>BELLE</u> Middle <u>SARVIN</u> Last | | 4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-5-1894</u> |
| 9. AGE (In years last birthday) <u>62</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>TILGHMAN MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>SAMUEL O. SARVIN</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNA S. SINCLAIR</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | |
| 17. INFORMANT <u>Hospital Records</u> | | Address <u>MT Wilson State Hospital</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARDIAC INSUFFICIENCY</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>3-12</u> 19 <u>57</u> , to <u>4-6-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-6</u> 19 <u>57</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>William Newcomer</u> M.D. | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) <u>William Newcomer</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>April 8, 57</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Tilghman Meth Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Tilghman Talbot Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John Moore</u> | | 24a. REC'D BY REGISTRAR <u>APR 9 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u> | | 24c. DATE | |

CERTIFICATE OF DEATH

Reg. No. 11

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. CAUSE OF DEATH
9. PLACE OF DEATH
10. DATE OF DEATH
11. SIGNATURE OF REGISTRAR
12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF CLERK

BUREAU V. 2

APR 9 1957

RECEIVED

3757

CERTIFICATE OF DEATH

Reg. Dist. No.

44

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 105 Days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4 | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 3611 Gelston Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ROBERT | | First ROBERT | | Middle W. | | Last GHEEN | | 4. DATE OF DEATH Month April | | Day 18 | | Year 19 57 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 30, 1895 | | 9. AGE (In years last birthday) yrs. 61 | | IF UNDER 1 YEAR Months 6 | | IF UNDER 24 HRS. Days 18 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker | | 10b. KIND OF BUSINESS OR INDUSTRY Baker Shop | | 11. BIRTHPLACE (State or foreign country) Jersey Shore, Penn. | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | |
| 13. FATHER'S NAME Charles Gheen | | | | 14. MOTHER'S MAIDEN NAME Catherine Johnson | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | (If yes, give war or dates of service) WW I | | 16. SOCIAL SECURITY NO. 215-16-2908 | | 17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF THE TONGUE WITH 141X GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | | |
| 21. I certify that I attended the deceased from January 3, 1957 , to April 18, 1957 , and that death occurred at 1:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Milton Ginsberg M.D. VAH, FORT HOWARD, MARYLAND 4/18/57 PHYSICIAN'S NAME (Type or print) MILTON GINSBERG, M.D., Asst. Chief, Surgical Service, VAH, Ft. Howard, Maryland | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 4-18-57 | | 22c. NAME OF CEMETERY OR CREMATORY Jersey Shore Cemetery | | | | 22d. LOCATION (City, town, or county) (State) Jersey Shore, Pennsylvania | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM COOK INC 1217 ST. APUL STREET Baltimore, Maryland | | | | | | 24a. REC'D BY REGISTRAR DATE 4-22-57 | | 24b. REGISTRAR'S SIGNATURE Lawson L. Fairley | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUROAU V. 8

APR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03748

3758

CERTIFICATE OF DEATH

Reg. Dist. No.

33

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mill | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mill x2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer Park Road | | d. STREET ADDRESS Deer Park Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Margaret Marie Glanville | | 4. DATE OF DEATH Month April Day 28 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 1, 1892 |
| 9. AGE (In years lost birthday) 65 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Frank Germac | | 14. MOTHER'S MAIDEN NAME Mary ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---- | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Chas. A. Glanville-Deer Park Rd.-Owings Mill | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis and (c) hypertension | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April , 1955, to April 28 , 1957, that I last saw the deceased alive on April 27 , 1956, and that death occurred at 6:45 M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Wm. E. Martin | | M.D. Ronald A. Heston ADDRESS (Street, city or town, state) Harrisonville, Maryland DATE SIGNED | |
| PHYSICIAN'S NAME (Type) William E. Martin, M. D. | | Harrisonville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/30/1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ELLSWORTH ARMACOST | | 24a. REC'D BY REGISTRAR MAY 2 1957 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Jones | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

MAY 2 1957

RECEIVED

3759

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b <u>14yrs11mth2dys</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Majerowicz</u> Last <u>Goralski</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>19 57</u> | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 26, 1876</u> | |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>housework</u> | | 11. BIRTHPLACE (State or foreign country) <u>Poland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>Poland</u> | | | | | | | |
| 13. FATHER'S NAME <u>Alonzo Majerowski</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | | 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | | | | | |
| 21. I certify that I attended the deceased from <u>April 13</u> , 19 <u>57</u> , to <u>April 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 16</u> , 19 <u>57</u> , and that death occurred at <u>3:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>4-16-57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> | | | | DATE SIGNED <u>4-16-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> | | | | <u>Catonsville 28, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>April 19, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>1300 Dundalk Ave+Balto, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>George A Weber</u> | | | | ADDRESS <u>705 South Ann Street</u> | | 24a. REC'D BY REGISTRAR DATE <u>APR 17 57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03750

Reg. Dist. No. 41

3690

| | | | | | | | |
|---|------------------------------|---|--------------------------------------|---|--------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>W. Virginia</u> b. COUNTY <u>Preston</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> | | c. LENGTH OF STAY IN 1b <u>10 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thornton 85 x 3</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>99 Baltimore Ave.</u> | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>DENZIL A. GRAHAM</u> | | | | 4. DATE OF DEATH Month Day Year <u>APR 24 19 57</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-25-1880</u> | 9. AGE (In years last birthday) <u>76</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u> | | 11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>P. Graham</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Tillie Liston</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>162-141165</u> | | 17. INFORMANT Address <u>Donald Graham 99 Baltimore Ave. Dundalk.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause pending for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial C-V Disease -</u> <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Central aneurism</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4/23/57</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>M. B. Davis</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>4/24/57</u> | |
| EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4-24-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>1st. Harriah Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Walky Point, W. Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Virgil's Funeral Home Dundalk, Md.</u> | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <u>4/25/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Wm. C. Kelly</u> | | | |

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

APR 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

0375144

3760

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY A.A. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | | | c. LENGTH OF STAY IN 1b 27 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First OLIVER Middle E. Last GREEK | | | | 4. DATE OF DEATH Month APRIL Day 14 Year 19 57 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-9-1908 | | 9. AGE (In years last birthday) 48 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN | | | | 10b. KIND OF BUSINESS OR INDUSTRY TRANSFORMER COMPANY BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME FRANK D. GREEK | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH CARROLL | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-11 | | 16. SOCIAL SECURITY NO. 215-10-0257 | | 17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA, METASTATIC, COLON 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 YEAR | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from MARCH 18 , 19 57 , to APRIL 14 , 19 57 , and that death occurred at 2:15 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Armen Bogosian | | | | ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. | | DATE SIGNED 4-14-57 | |
| PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M. D. | | | | VAH, Fort Howard, Md. | | 4-14-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF April 15-57 | | 22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY | | 22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fink's Funeral Parlor | | | | ADDRESS 5th Ave. & Crain Hwy | | 24a. REC'D BY REGISTRAR DATE 4-16-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Ramson L. Garber | | | |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

037528

3761

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baynesville 34 | | c. LENGTH OF STAY IN 1b x2 Baynesville Baltimore 34 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 1915 E. Joppa Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOHN GROSS | | 4. DATE OF DEATH April 13, 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 26, 1881 |
| 9. AGE (In years and months) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Benchworker-retired | | 10b. KIND OF BUSINESS OR INDUSTRY Tool Mfg. Co. | |
| 11. BIRTHPLACE (State or foreign country) Austria | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Mathias Gross | | 14. MOTHER'S MAIDEN NAME Elizabeth Schisler | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 212-10-9786 | |
| 17. INFORMANT Family records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/15 , 19 53 , to 4/13 , 19 57 , that I last saw the deceased alive on 4/13 , 19 57 , and that death occurred at 10:34 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Gordon Grau | | ADDRESS (Street, city or town, state) 8513 1/2th Raven Blvd Towson, Md | |
| PHYSICIAN'S NAME (Type) GORDON GRAU MD | | DATE SIGNED 4/15/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 16, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Towson, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons | | 24a. REC'D BY REGISTRAR APR 17 1957 | |
| ADDRESS Towson, Maryland | | 24b. REGISTRAR'S SIGNATURE Dr. R. M. Bacon | |

CERTIFICATE OF DEATH

3721

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|-------|--|---------------|--|----------------|--|-----------------|--|--------------------|--|-----------------|--|----------------|--|---------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Place of Death | | Time of Death | | Signature of Registrar | | Signature of Physician | |
| John A. Smith | | Male | | 45 | | Jan 15 1880 | | Boston, Mass. | | Boston, Mass. | | Heart Disease | | Jan 10 1925 | | Boston, Mass. | | 10:30 AM | | J. A. Smith | | J. A. Smith | |
| Occupation | | Marital Status | | Color | | Height | | Weight | | Education | | Previous Illnesses | | Manner of Death | | Burial Place | | Burial Date | | Burial Time | | Burial Signature | |
| Teacher | | Married | | White | | 5'8" | | 170 lbs | | High School | | None | | Natural | | Catholic | | Jan 12 1925 | | 11:00 AM | | J. A. Smith | |

BUREAU V. 2

APR 17 1925

RECEIVED

| | | | | | | | | | | | | | | | |
|-------------------|--|------------------------|--|-------------------|--|------------------------|--|----------------------|--|---------------------------|--|---------------------|--|--------------------------|--|
| Name of Registrar | | Signature of Registrar | | Name of Physician | | Signature of Physician | | Name of Burial Place | | Signature of Burial Place | | Name of Burial Date | | Signature of Burial Date | |
| J. A. Smith | | J. A. Smith | | J. A. Smith | | J. A. Smith | | Catholic | | Catholic | | Jan 12 1925 | | Jan 12 1925 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

| STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 03753 |
|--|--|----------------------------------|---|--|--|---|--|---|--|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b <u>15 hours</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk, Maryland</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u> | | | | | d. STREET ADDRESS <u>2479 Fairway</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>WILLIAM</u> Last <u>Halenar</u> | | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>19 57</u> | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 25, 1913</u> | | 9. AGE (In years last birthday) <u>43</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | |
| 13. FATHER'S NAME <u>William Halenar</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Stephanie</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u> | | | | | 16. SOCIAL SECURITY NO. <u>213-09-3529</u> | | 17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>322.1</u> DUE TO (b) <u>Delirium tremans</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Chronic Alcoholism</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | | |
| 22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | 22b. DATE THEREOF <u>4-15-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Brooks Bradley Inc. Dundalk, Md.</u> | | | | | 24a. REC'D BY REGISTRAR <u>APR 15 '57</u> | | 24b. REGISTRAR'S SIGNATURE <u>D. Kieffer</u> | | | |

BUREAU V. S.

APR 15 1957

RECEIVED

3763

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Baltimore 3401.4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS 3014 Mayfield Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle Hamilton Last Hamilton | | | | 4. DATE OF DEATH Month April Day 15 Year 19 57 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 23 1868 | 9. AGE (In years last birthday) 89 yrs. | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. | | IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY housework | | 11. BIRTHPLACE (State or foreign country) England | | 12. CITIZEN OF WHAT COUNTRY? England | |
| 13. FATHER'S NAME Evan Owen | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Hughes | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive heart failure DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic mitral rheumatic endocarditis | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 1 , 19 57 , to April 15 , 19 57 , that I last saw the deceased alive on April 15 , 19 57 , and that death occurred at 2:20 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Stella Wachslar | | | | M.D. SPRING GROVE STATE HOSPITAL 4-15-57 | | | |
| PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | | | Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 18, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington | | 22d. LOCATION (City, town, or county) (State) Philadelphia, Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hand. A. Cole | | | | 24a. REC'D BY REGISTRAR 1913 W. Baltimore | | 24b. REGISTRAR'S SIGNATURE DATE APR 18 57 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03755

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3761

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4 | |
| c. LENGTH OF STAY IN 1b 2yr6mth18dys | | d. STREET ADDRESS 116 S. Gilmore Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Oliver Middle Roy Last Hands | | 4. DATE OF DEATH Month April Day 30 Year 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 12, 1890 |
| 9. AGE (In years last birthday) 67 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) boiler maker | | 10b. KIND OF BUSINESS OR INDUSTRY B & O R.R. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Lewis D. Hands | | 14. MOTHER'S MAIDEN NAME Martha DeGroffe | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO. 705-07-6495 | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Fracture of left hip | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) On 3-14-57 Insertion of three Knowles pins in frac. left hip | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. slipped from bench to floor on 3-8-57 sustaining a fractured left hip | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 9:00 p.m. 3-8-57 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital | | 20f. (City or town) (County) (State) Catonsville 28, Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Geo. M. Kieffer</i> | | DATE SIGNED 4-30-57 | |
| EXAMINER'S NAME (Type) George M. Kieffer, M. D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/9-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 22d. LOCATION (City, town, or county) (State) 3801 Frederick Ave Ind | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robt C. B. Walters</i> | | 24a. REC'D BY REGISTRAR MAY 2 '57 | |
| ADDRESS <i>121 S. Stricker St</i> | | 24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

RECEIVED

MAY 2 1957

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
CITY OF DEATH: [illegible]
COUNTY OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
DISEASE OR INJURY: [illegible]
IMMEDIATE CAUSE: [illegible]
UNDERLYING CAUSE: [illegible]
MORBIDITY: [illegible]
MORTALITY: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3765

CERTIFICATE OF DEATH

Reg. Dist. No. 0375631

| | | | | | | | |
|--|---------------------------|--|----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Woodlawn</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Rural - WOODLAWN</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5003 Englewood Ave</u> | | | | d. STREET ADDRESS <u>12003 ENGLEWOOD AVE</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA ARBURTA HARR</u> | | | | 4. DATE OF DEATH Month Day Year <u>4 1 19 57</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/9/1873</u> | 9. AGE (In years last birthday) <u>83</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWORK</u> | 11. BIRTHPLACE (State or foreign country) <u>CARROLL COUNTY, MD.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>ANDREW FRESH</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ALICE MASENHEIMER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>DAUGHTER</u> Address <u>MILDRED HARR 2003 ENGLEWOOD AVE BALTO.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OVARY METASTASES</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>SEPT. 26, 1956</u> to <u>APRIL 1, 1957</u> , that I last saw the deceased alive on <u>MARCH 29, 1957</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Edwin J. Pierpont</u> | | | | ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD. BALTO. 7, MD.</u> DATE SIGNED <u>APR 1 1957</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Edwin J. Pierpont</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/3/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Krieders Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lichtenow - Balt. 17, Md.</u> ADDRESS _____ | | | | 24a. REC'D BY REGISTRAR <u>4/3/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. S. Martin</u> | |

MARTLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 72

BUREAU V. S.

APR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03757
43

Reg. Dist. No.

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Balto.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fitch Lane</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Baltimore (Fullerton)</u> d. STREET ADDRESS <u>Fitch Lane</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>G.</u> Last <u>Heim</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1957</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec. 18, 1901</u> | | 9. AGE (years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Totally Disabled</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Frederick S. Heim</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Reis</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Joseph C. Heim Box 500A Fitch Lane</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH <u>Summed</u> </div> </div> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>John C. Hyle</u> | | | | DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u> | | | | <u>4-24-57</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>April 27, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lissahn Funeral Home</u> | | | | ADDRESS <u>7401 Belair Rd.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 29 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Ruffenberger</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3767

CERTIFICATE OF DEATH

Reg. Dist. No.

03758
28

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Parkville</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3014 Woodside Avenue</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. John Roland Heiss</i> | | | | 4. DATE OF DEATH Month Day Year <i>April 9th 19 57</i> | | | |
| 5. SEX <i>male</i> | | 6. COLOR OR RACE <i>white</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>July 20, 1894</i> | |
| 9. AGE (In years last birthday) <i>62</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>William S. Heiss</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Annie Betz</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war or dates of service) <i>WW I</i> | | | | 16. SOCIAL SECURITY NO. <i>218-03-6266</i> | | 17. INFORMANT Address <i>Mrs. Marie A. Heiss, 3014 Woodside Ave</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Coronary thrombosis</i> DUE TO (c) <i>a</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i> <i>4 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <i>Feb</i> 19 <i>57</i> , to <i>March 9, 1957</i> , that I last saw the deceased alive on <i>March 6, 1957</i> , and that death occurred at <i>6:10 PM</i> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <i>8106 Harford Rd</i> DATE SIGNED <i>4-9-57</i> | | | | | | | |
| ACTUAL SIGNATURE <i>Harold H. Burns</i> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>Harold H. Burns</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>4/12/57</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck Inc</i> ADDRESS <i>5305 Harford Road</i> | | | | 24a. REC'D BY REGISTRAR <i>APR 11 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

APR 11 1957

BUREAU V. R.

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

THIS CERTIFICATE OF DEATH IS TO BE FILED IN THE BUREAU OF VITAL RECORDS, DEPARTMENT OF HEALTH, COMMONWEALTH OF MASSACHUSETTS, AND IS TO BE MAINTAINED IN THE BUREAU OF VITAL RECORDS, DEPARTMENT OF HEALTH, COMMONWEALTH OF MASSACHUSETTS, FOR A PERIOD OF FIFTY YEARS AFTER THE DATE OF DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3768 CERTIFICATE OF DEATH

03759

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|---|----------------------------------|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS unknown 1908 Liberty Heights Ave | | | |
| 3. NAME OF DECEASED (Type or print) First Axel Middle M. Last Hendrickson | | | | 4. DATE OF DEATH Month April Day 24 Year 19 57 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 18, 1886 | |
| 9. AGE (In years last birthday) 71 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Finland | |
| 13. FATHER'S NAME Matt Henderson | | | | 14. MOTHER'S MAIDEN NAME Sophie Hemming | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 18 , 19 57 , to April 24 , 19 57 , that I last saw the deceased alive on April 24 , 19 57 , and that death occurred at 2:40p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-24-57 | | | | | | | |
| ACTUAL SIGNATURE Stella Wachslar M.D. | | | | PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 4/25/57 | | 22c. NAME OF CEMETERY OR CREMATORY Douglas Cem. | | 22d. LOCATION (City, town, or county) (State) Douglas, Ga. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Tiekner & Sons - Baltimore | | | | 24a. REC'D BY REGISTRAR DATE APR 25 '57 | | 24b. REGISTRAR'S SIGNATURE Carl Smith | |

CERTIFICATE OF DEATH

1957

| | | | |
|---------------------------------|--|----------------------------|--|
| PLACE OF DEATH HOME | | PLACE OF BIRTH HOME | |
| SEX MALE | | AGE 20 | |
| RACE WHITE | | OCCUPATION STUDENT | |
| MARITAL STATUS SINGLE | | EDUCATION HIGH SCHOOL | |
| DATE OF DEATH APRIL 26, 1957 | | TIME OF DEATH 10:00 AM | |
| CAUSE OF DEATH HEART DISEASE | | MANNER OF DEATH NATURAL | |
| PLACE OF DEATH HOME | | PLACE OF BIRTH HOME | |
| SEX MALE | | AGE 20 | |
| RACE WHITE | | OCCUPATION STUDENT | |
| MARITAL STATUS SINGLE | | EDUCATION HIGH SCHOOL | |
| DATE OF DEATH APRIL 26, 1957 | | TIME OF DEATH 10:00 AM | |
| CAUSE OF DEATH HEART DISEASE | | MANNER OF DEATH NATURAL | |

BUREAU V. 2

APR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G211, 4-30-57 et

03760

3769

CERTIFICATE OF DEATH

Reg. Dist. No.

45

| | | | | |
|---|-------------------------------|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 547 Middle River | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 11601 Wilson Point Road | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First LEONARD Middle D. Last HENRICKS | | 4. DATE OF DEATH Month April Day 16 , Year 1957 | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 6, 1881 | |
| 9. AGE (In years last birthday) 75 1/2 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10b. KIND OF BUSINESS OR INDUSTRY Police Dept. | | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME William Henricks | | 14. MOTHER'S MAIDEN NAME Minnie Ebbinghouse | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Emma Gearish Henricks, wife, above | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio-sclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Drabsten Mellitus | | | | INTERVAL BETWEEN ONSET AND DEATH 2 mo. 10 yrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from May 3 , 19 47 , to April 16 , 19 57 , that I last saw the deceased alive on April 15 , 19 57 , and that death occurred at 11:40 A.M. from the causes and on the date stated above. | | | | |
| ACTUAL SIGNATURE Joseph Miceli M.D. | | ADDRESS (Street, city or town, state) 105 S. Taylor DATE SIGNED 4/12/57 | | |
| PHYSICIAN'S NAME (Type) JOSEPH MICELI | | Joseph 2nd | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/19/57 | 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem. | |
| 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS 3331 Brehms Lane | | 24a. RECEIVED BY REGISTRAR APR 22 1957 DATE | | |
| 24b. REGISTRAR'S SIGNATURE Edith Amberg | | | | |

CERTIFICATE OF DEATH

Form No. 10

3780

| | | | | | | | |
|--|--|-----------------------------------|--|---------------------------------|--|----------------------------------|--|
| <p>1. NAME OF DECEASED</p> | | <p>2. SEX</p> | | <p>3. AGE</p> | | <p>4. DATE OF BIRTH</p> | |
| <p>5. PLACE OF BIRTH</p> | | <p>6. OCCUPATION</p> | | <p>7. CAUSE OF DEATH</p> | | <p>8. MANNER OF DEATH</p> | |
| <p>9. DATE OF DEATH</p> | | <p>10. TIME OF DEATH</p> | | <p>11. PLACE OF DEATH</p> | | <p>12. SIGNATURE OF DECEASED</p> | |
| <p>13. SIGNATURE OF WITNESSES</p> | | <p>14. SIGNATURE OF PHYSICIAN</p> | | <p>15. SIGNATURE OF CORONER</p> | | <p>16. SIGNATURE OF JUDGE</p> | |
| <p>17. SIGNATURE OF CLERK</p> | | <p>18. SIGNATURE OF REGISTRAR</p> | | <p>19. SIGNATURE OF NOTARY</p> | | <p>20. SIGNATURE OF SHERIFF</p> | |
| <p>21. SIGNATURE OF DEPUTY SHERIFF</p> | | <p>22. SIGNATURE OF JURY</p> | | <p>23. SIGNATURE OF COURT</p> | | <p>24. SIGNATURE OF JUDGE</p> | |
| <p>25. SIGNATURE OF CLERK</p> | | <p>26. SIGNATURE OF REGISTRAR</p> | | <p>27. SIGNATURE OF NOTARY</p> | | <p>28. SIGNATURE OF SHERIFF</p> | |
| <p>29. SIGNATURE OF DEPUTY SHERIFF</p> | | <p>30. SIGNATURE OF JURY</p> | | <p>31. SIGNATURE OF COURT</p> | | <p>32. SIGNATURE OF JUDGE</p> | |
| <p>33. SIGNATURE OF CLERK</p> | | <p>34. SIGNATURE OF REGISTRAR</p> | | <p>35. SIGNATURE OF NOTARY</p> | | <p>36. SIGNATURE OF SHERIFF</p> | |
| <p>37. SIGNATURE OF DEPUTY SHERIFF</p> | | <p>38. SIGNATURE OF JURY</p> | | <p>39. SIGNATURE OF COURT</p> | | <p>40. SIGNATURE OF JUDGE</p> | |
| <p>41. SIGNATURE OF CLERK</p> | | <p>42. SIGNATURE OF REGISTRAR</p> | | <p>43. SIGNATURE OF NOTARY</p> | | <p>44. SIGNATURE OF SHERIFF</p> | |
| <p>45. SIGNATURE OF DEPUTY SHERIFF</p> | | <p>46. SIGNATURE OF JURY</p> | | <p>47. SIGNATURE OF COURT</p> | | <p>48. SIGNATURE OF JUDGE</p> | |
| <p>49. SIGNATURE OF CLERK</p> | | <p>50. SIGNATURE OF REGISTRAR</p> | | <p>51. SIGNATURE OF NOTARY</p> | | <p>52. SIGNATURE OF SHERIFF</p> | |
| <p>53. SIGNATURE OF DEPUTY SHERIFF</p> | | <p>54. SIGNATURE OF JURY</p> | | <p>55. SIGNATURE OF COURT</p> | | <p>56. SIGNATURE OF JUDGE</p> | |
| <p>57. SIGNATURE OF CLERK</p> | | <p>58. SIGNATURE OF REGISTRAR</p> | | <p>59. SIGNATURE OF NOTARY</p> | | <p>60. SIGNATURE OF SHERIFF</p> | |
| <p>61. SIGNATURE OF DEPUTY SHERIFF</p> | | <p>62. SIGNATURE OF JURY</p> | | <p>63. SIGNATURE OF COURT</p> | | <p>64. SIGNATURE OF JUDGE</p> | |
| <p>65. SIGNATURE OF CLERK</p> | | <p>66. SIGNATURE OF REGISTRAR</p> | | <p>67. SIGNATURE OF NOTARY</p> | | <p>68. SIGNATURE OF SHERIFF</p> | |
| <p>69. SIGNATURE OF DEPUTY SHERIFF</p> | | <p>70. SIGNATURE OF JURY</p> | | <p>71. SIGNATURE OF COURT</p> | | <p>72. SIGNATURE OF JUDGE</p> | |
| <p>73. SIGNATURE OF CLERK</p> | | <p>74. SIGNATURE OF REGISTRAR</p> | | <p>75. SIGNATURE OF NOTARY</p> | | <p>76. SIGNATURE OF SHERIFF</p> | |
| <p>77. SIGNATURE OF DEPUTY SHERIFF</p> | | <p>78. SIGNATURE OF JURY</p> | | <p>79. SIGNATURE OF COURT</p> | | <p>80. SIGNATURE OF JUDGE</p> | |
| <p>81. SIGNATURE OF CLERK</p> | | <p>82. SIGNATURE OF REGISTRAR</p> | | <p>83. SIGNATURE OF NOTARY</p> | | <p>84. SIGNATURE OF SHERIFF</p> | |
| <p>85. SIGNATURE OF DEPUTY SHERIFF</p> | | <p>86. SIGNATURE OF JURY</p> | | <p>87. SIGNATURE OF COURT</p> | | <p>88. SIGNATURE OF JUDGE</p> | |
| <p>89. SIGNATURE OF CLERK</p> | | <p>90. SIGNATURE OF REGISTRAR</p> | | <p>91. SIGNATURE OF NOTARY</p> | | <p>92. SIGNATURE OF SHERIFF</p> | |
| <p>93. SIGNATURE OF DEPUTY SHERIFF</p> | | <p>94. SIGNATURE OF JURY</p> | | <p>95. SIGNATURE OF COURT</p> | | <p>96. SIGNATURE OF JUDGE</p> | |
| <p>97. SIGNATURE OF CLERK</p> | | <p>98. SIGNATURE OF REGISTRAR</p> | | <p>99. SIGNATURE OF NOTARY</p> | | <p>100. SIGNATURE OF SHERIFF</p> | |

BUREAU V. 3

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03761

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale | | | | c. LENGTH OF STAY IN 1b X Rosedale | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1309 Rosewick Ave | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First BESSIE Middle MABEL Last HILTZ | | | | 4. DATE OF DEATH Month April Day 27 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-20-1897 | |
| 9. AGE (in years last birthday) 59 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | 10. AGE (in years last birthday) 59 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Eastern Shore Md | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME John Donoho | | | |
| 14. MOTHER'S MAIDEN NAME X Carrie Young | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Henry Hiltz 1309 Rosewick Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot Wound...Left breast DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic Cancer...Depression | | | | | | | |
| 19. INTERVAL BETWEEN ONSET AND DEATH INST | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Self inflicted Gun Shot Wound | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 1:30 Hour XX p. m. 4-27 1957 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 20f. (City or town) (County) (State) Rosedale Balto Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE John C. Hyle | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John C. Hyle MD | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED 4-28-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 4-30-57 | | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum | | 22d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc.-2431 E. Oliver St. | | | | 24. REGD BY REGISTRAR MAY 1 1957 | | | |
| 25. REGISTRAR'S SIGNATURE Edith Harkins | | | | 26. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3700

CERTIFICATE OF DEATH

Reg. Dist. No.

03762

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 51 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4313 Leeds Avenue | | d. STREET ADDRESS 4313 Leeds Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Bertha Middle Hohman Last | | 4. DATE OF DEATH Month April Day 9 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 13, 1902 |
| 9. AGE (In years last birthday) 54 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Preston, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME George Haverkamp | | 14. MOTHER'S MAIDEN NAME Anna Henning | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-0-6177 | |
| 17. INFORMANT Clarence J. Hohman, Sr. | | Address 4313 Leeds Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus & Arteriosclerosis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2/4 , 19 55 , to 4/9 , 19 57 , that I last saw the deceased alive on 4/9 , 19 57 , and that death occurred at 1038 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 27, md DATE SIGNED 4/9/57 | | | |
| ACTUAL SIGNATURE John C. Healy M.D. | | DATE SIGNED 4/9/57 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/12/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard | | ADDRESS 4107 Wilkens Avenue | |
| 24a. REC'D BY REGISTRAR DATE 4/15/1957 | | 24b. REGISTRAR'S SIGNATURE Dr. E. M. Kueppers | |

BUREAU V. S.

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3771

CERTIFICATE OF DEATH

03763

Reg. Dist. No.

40

| | | | | | | | |
|---|----------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fork</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Fork</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fork + Bottom Rds.</u> | | | | d. STREET ADDRESS <u>1 Fork + Bottom Rds.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Bernard</u> First Middle Last <u>C. Holland</u> | | | | 4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 8, 1888</u> | | 9. AGE (In years last birthday) <u>68</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Blacksmith</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto. Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Carville Holland</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eliza Jane Isenock</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-34-5772</u> | | 17. INFORMANT <u>Mrs. Annie M. Holland</u> | | Address <u>Fork + Bottom Rds.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive CVD</u> (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>20 yrs. +</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March</u> , 1955, to <u>April</u> , 1957, that I last saw the deceased alive on <u>April 11</u> , 1957, and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>William A. Tyson</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>William A. Tyson</u> | | | | DATE SIGNED <u>4-25-57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>April 29 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u> | | 22d. LOCATION (City, town, or county) (State) <u>Long Green Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Luach Funeral Home</u> | | | | ADDRESS <u>7401 Belair Rd</u> | | 24a. REC'D BY REGISTRAR <u>APR 29 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Dr. Walter H. Harnett</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME: *William C. Holland*
 SEX: *Male*
 AGE: *48*
 DATE OF BIRTH: *May 10, 1900*
 PLACE OF BIRTH: *St. Louis, Mo.*
 OCCUPATION: *Electrician*
 CAUSE OF DEATH: *Heart Disease*
 PLACE OF DEATH: *Home*
 DATE OF DEATH: *April 29, 1957*
 SIGNATURE: *W. C. Holland*
 WITNESSES: *John C. Holland, Mary C. Holland*

BUREAU V. 2

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3772

CERTIFICATE OF DEATH

03764

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIUM c. LENGTH OF STAY IN 1b TIMONIUM d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 E. MAIN BLVD. | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIUM d. STREET ADDRESS 9 E. MAIN BLVD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) LAURA CAVANAUGH HOOK First Middle Last | | | | 4. DATE OF DEATH Month APRIL Day 25 Year 1957 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH FEB-7- | |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months 2 Days 17 Hours Min. | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND | | 11. BIRTHPLACE (State or foreign country) U-S-A. | |
| 13. FATHER'S NAME ROBERT WHINNER | | | | 14. MOTHER'S MAIDEN NAME LAURA WILSON. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT LILLIAN W. HOOK - TIMONIUM-MD. Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 360x (b) auricular fibrillation DUE TO (c) arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Gangrene left leg; Diabetes mellitus | | | | | | INTERVAL BETWEEN ONSET AND DEATH 14 days 2 yrs 10 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/1 , 19 57 , to 4/25 , 19 57 , that I last saw the deceased alive on 4/25 , 19 57 , and that death occurred at 9 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lutherville, Md. DATE SIGNED 4/26/57 ACTUAL SIGNATURE George T. Gilmore M.D. PHYSICIAN'S NAME (Type) G. T. GILMORE, MD LUTHERVILLE, MD. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF APRIL-29/57 | | 22c. NAME OF CEMETERY OR CREMATORY SLATE-RIDGE | | 22d. LOCATION (City, town, or county) (State) DELTA - PENNSYLVANIA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WM COOK TOWSON, INC - 1050 YORK RD ADDRESS | | | | 24a. REC'D BY REGISTRAR APR 29 57 | | 24b. REGISTRAR'S SIGNATURE | |

BUREAU V. 3

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03765

3773

CERTIFICATE OF DEATH

Reg. Dist. No.

44

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 177 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 7409 North Point Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CLARENCE E. HUDSON | | | | 4. DATE OF DEATH Month Day Year April 18 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 10, 1906 | |
| 9. AGE (In years last birthday) yrs. 50 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian | | 10b. KIND OF BUSINESS OR INDUSTRY Public School | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Lillian MN: Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service) Yes WW II | | 16. SOCIAL SECURITY NO. 213-09-1430 | | 17. INFORMANT Address Clin/Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that VA attended the deceased from October 23, 1956 , to April 18, 1957 , and that death occurred at 8:20 A.M. , from the causes and on the date stated above. CHIEF OF CHIEF OF CHIEF OF CHIEF OF CHIEF OF CHIEF OF CHIEF OF CHIEF OF ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 4/18/57 PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 4/22/57 | | 22c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons, 2024 Orleans St., Balto, Md. | | | | 24a. REC'D BY REGISTRAR APR 22 1957 | | 24b. REGISTRAR'S SIGNATURE Dawson L. Fisher | |

BUREAU V. S.

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03766

3774

CERTIFICATE OF DEATH

Reg. Dist. No.

45

| | | | |
|---|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> <u>312 E. Riverside Ave</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Back River</u> | | c. LENGTH OF STAY IN 1b <u>6 yrs.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>x0</u> | | d. STREET ADDRESS <u>312 E. Riverside Ave</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>M.</u> Middle <u>Humphrey</u> Last | | 4. DATE OF DEATH <u>April</u> Month <u>14</u> Day <u>1957</u> Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 15/1900</u> |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Peter Chm</u> | | 14. MOTHER'S MAIDEN NAME <u>Johanna Schmidt</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Robert F. Humphrey</u> | | Address <u>312 E. Riverside Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic carcinoma</u> DUE TO (c) <u>Ca of breast</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 mos.</u> <u>1 yr.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan., 1952</u> to <u>4/14, 1957</u> that I last saw the deceased alive on <u>4/13, 1957</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. Platt</u> | | ADDRESS (Street, city or town, state) <u>434 Eastern Ave.</u> DATE SIGNED <u>4/15/57</u> | |
| PHYSICIAN'S NAME (Type) <u>J. PLATT</u> | | <u>E. Platt M.D.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/17/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Herwig</u> | | ADDRESS <u>2024 Orlean St</u> | |
| 24a. REC'D BY REGISTRAR <u>Edith Hurler</u> | | DATE <u>4-16-57</u> | |
| 24b. REGISTRAR'S SIGNATURE | | | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

| | | | | | | | | | | | |
|-----------------------|--|----------------------|--|--------------------------------|--|------------------------|--|-------------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES J. JONES | | 45 | | M | | W | | 1912 | | NEW YORK | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | | MEDICAL ATTENDANT | |
| APR 15 1957 | | HOSPITAL | | HEART DISEASE | | NATURAL | | CORONARY ARTERY DISEASE | | DR. J. J. JONES | |
| TIME OF DEATH | | HOURS | | MINUTES | | TEMPERATURE | | PULSE | | BLOOD PRESSURE | |
| 10:00 AM | | 10 | | 00 | | 98.6 | | 60 | | 120/80 | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF MEDICAL ATTENDANT | | SIGNATURE OF REGISTRAR | | SIGNATURE OF CLERK | | SIGNATURE OF NURSE | |
| JAMES J. JONES | | JOHN J. JONES | | J. J. JONES | | J. J. JONES | | J. J. JONES | | J. J. JONES | |

RECEIVED
 APR 16 1957
 BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 12 FilmG215 5-15-57 et
3775
CERTIFICATE OF DEATH

03767

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 6 Mo. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines 16 Rusting Ave | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | | | |
| | | | | d. STREET ADDRESS 2525 Hollins St. | | | |
| 3. NAME OF DECEASED (Type or print) First Lillian Middle C. Last James | | | | 4. DATE OF DEATH Month April Day 6 Year 1957 | | | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 25, 1880 | | 9. AGE (In years last birthday) yrs. 76 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY O.H. | | 11. BIRTHPLACE (State or foreign country) England | | 12. CITIZEN OF WHAT COUNTRY? 55/NYS U.S.A. | |
| 13. FATHER'S NAME Horace Ring | | | | 14. MOTHER'S MAIDEN NAME Alice Merriett | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address #28 Mrs Violet Marshall, 1206 Brandford Rd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chs. Hypertensive Cardio-Vasc. Renal Disease DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 da. 10 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 10-11 , 19 56 , to 4-6 , 19 57 , that I last saw the deceased alive on 4-6 , 19 57 , and that death occurred at 4:30 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William K. Gallager | | | | ADDRESS (Street, city or town, state) 6209 Frederick Ave. Baltimore 28, Md. | | | |
| PHYSICIAN'S NAME (Type) William K. Gallager | | | | DATE SIGNED 4/8/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 10/57 | | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 22d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave. | | | | 24a. REC'D BY REGISTRAR DATE APR 10 57 | | 24b. REGISTRAR'S SIGNATURE Overhach | |

APR 10 1957

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03768

3776

CERTIFICATE OF DEATH

Reg. Dist. No.

45

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harbor View | | | | c. LENGTH OF STAY IN 1b 64 Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7101 Fait Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last John Frank Janiszewski | | | | 4. DATE OF DEATH Month Day Year April 10 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 13 1882 | |
| 9. AGE (In years last birthday) 75 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Janiszewski | | | | 14. MOTHER'S MAIDEN NAME Anna Zakrzewski | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema INTERVAL BETWEEN ONSET AND DEATH 2 days 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion 3 days DUE TO (c) Hypertension 10 years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from April 4, 1957 , to April 10, 1957 , that I last saw the deceased alive on April 10, 1957 , and that death occurred at 1 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Morris A. Jacobs M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED 1010 North Point Rd 4/11/57 | | | |
| PHYSICIAN'S NAME (Type) MORRIS A JACOBS | | | | 1010 NORTH POINT RD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4/13/57 | | 22c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM. | | 22d. LOCATION (City, town, or county) (State) GERMAN HILL RD MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Baker | | | | ADDRESS 4015 Chestnut | | 24a. REC'D BY REGISTRAR DATE 4-12-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Edith Hurley | | | |

RECEIVED
JAN 15 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

369 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03769 41
Reg. Dist. No.

| | | | |
|---|-----------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> Turner Station | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 302 Wheeler Court | | d. STREET ADDRESS 302 Wheeler Court | |
| 3. NAME OF DECEASED (Type or print) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| First DAVID | | Last JOHNSON | |
| 4. DATE OF DEATH | | Month April Day 6 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 30, 1934 |
| 9. AGE (In years last birthday) 22 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Walter Johnson | | 14. MOTHER'S MAIDEN NAME Fannie Bolden | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Walter Johnson - 302 Wheeler Court | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epilepsy</u> 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>15 yrs</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE M B Davis | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) M B Davis M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-10-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law | | ADDRESS 802 Madison Avenue | |
| 24a. REC'D BY REGISTRAR DATE 4/8/57 | | 24b. REGISTRAR'S SIGNATURE Wm. Kelly | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

APR 9 1957

RECEIVED

3777

CERTIFICATE OF DEATH

03770

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|---|---|---|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u> | | | | d. STREET ADDRESS <u>3004 Dupont Ave.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Kagle</u> Last <u>Kagle</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 10 1877</u> | 9. AGE (In years last birthday) <u>79</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired General Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u> | | 11. BIRTHPLACE (State or foreign country) <u>U. S</u> | |
| 13. FATHER'S NAME <u>Wm. F Kagle</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary C. Lucabaugh</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Geo. L. Martin 3004 Dupont Ave. Baltimore</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thromboses</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 p.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. Lymphatic Leukemia</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4-28</u> , 19 <u>57</u> , to <u>4-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-23</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> A.M., from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D. | | | | <u>6209 Frederick Rd. 4-25-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u> | | | | <u>Catonsville-28, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/26/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u> | | 22d. LOCATION (City, town, or county) (State) <u>Dunell Co Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Lipton - Hampstead Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>4-20-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

APR 29 1957

RECEIVED

3778

CERTIFICATE OF DEATH

Reg. Dist. No.

44

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 28 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | |
| 4. NAME OF DECEASED (Type or print) First RALPH Middle E. Last KAVE | | 4. DATE OF DEATH Month April Day 28 Year 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 22, 1917 |
| 9. AGE (In years last birthday) 39 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Oil Company | |
| 11. BIRTHPLACE (State or foreign country) Hubbard, W. Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Alvin Kave | | 14. MOTHER'S MAIDEN NAME Bessie Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW II | | 16. SOCIAL SECURITY NO. 220-10-0835 | |
| 17. INFORMANT Clin. Recs. Vet. Admin. Hosp., Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LUNG ABSCESS, LEFT. PERICARDITIS | | INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 31 , 19 57 , to April 28 , 19 57 , and that death occurred at 5:40A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Chienwei Lan | | DATE SIGNED 4/28/57 | |
| PHYSICIAN'S NAME (Type) CHIENTWEI LAN, M. D. | | ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF April 30, 1957 | 22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Vernon C. Lemmon Funeral Home | | 24a. REC'D BY REGISTRAR APR 30 1957 | |
| ADDRESS 4611 Park Heights Ave., Baltimore, Md. | | 24b. REGISTRAR'S SIGNATURE L. L. L. L. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

98

0000-0000-0000-0000

10-10-86

BUREAU V. S.

APR 30 1957

RECEIVED

3779
CERTIFICATE OF DEATH

Reg. Dist. No. 44

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 59 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3 Vol-4 4316 Eldone Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First FLOYD Middle J. Last KENDALL | | | | 4. DATE OF DEATH Month April Day 8 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/10/12 | |
| 9. AGE (In years last birthday) 45 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bread salesman | | | | 10b. KIND OF BUSINESS OR INDUSTRY Bakery | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME John Kendall | | | | 14. MOTHER'S MAIDEN NAME Theresa Mutuska | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 212-01-4433 | | 17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) UNKNOWN | | INTERVAL BETWEEN ONSET AND DEATH 1 DAY | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INCISIONAL HERNIA - Duration unknown | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that VA attended the deceased from February 8 , 19 57 , to April 8 , 19 57 , and that death occurred at 4:15 P. M. from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE Irving Freeman M.D. Veterans Administration Hospital | | | | 4/9/57 | | | |
| PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, FORT HOWARD, MARYLAND | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-12-57 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc | | | | 24. REC'D BY REGISTRAR APR 17 1957 | | | |
| ADDRESS 6009 Harford Road, Balto., Md. | | | | 24b. REGISTRAR'S SIGNATURE Lewis L. Barber | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|------------------|--|
| Name of deceased | | John Doe | |
| Sex | | Male | |
| Age | | 45 | |
| Date of birth | | 1910-01-15 | |
| Place of birth | | New York, U.S.A. | |
| Cause of death | | Heart disease | |
| Date of death | | 1957-04-10 | |
| Place of death | | New York, U.S.A. | |
| Signature of physician | | [Signature] | |
| Signature of registrar | | [Signature] | |

BUREAU V. S.

APR 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3780

Reg. Dist. No. 37

03773

| | | | | | | | |
|---|---------------------------|--|--------------------------------------|---|-----------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>BALTO.</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2518 N. ROLLING RD</u> | | | | d. STREET ADDRESS <u>2518 N. ROLLING RD</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>VINCENT</u> Middle <u>ANTHONY</u> Last <u>KICAS</u> | | | | 4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 1, 1890</u> | 9. AGE (In years last birthday) <u>66</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>TAILOR</u> | | 11. BIRTHPLACE (State or foreign country) <u>LITHUAINA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>NOT KNOWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>215-01-0583</u> | | 17. INFORMANT <u>ANTHONY KICAS - SON - 2518 ROLLING RD - 7</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEUKEMIA</u> <u>204.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>54</u> , to <u>APRIL 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>APRIL 24</u> , 19 <u>57</u> , and that death occurred at <u>3:10 P. M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> | | | | ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD, BALTO 7, MD</u> | | | |
| PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT</u> | | | | DATE SIGNED <u>4/24/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>4/27/7</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>LOTHRINE Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Scharlach</u> | | | | ADDRESS <u>703 McHenry St.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 4/24/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Pr. Wm. Martin</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

APR 26 1957

RECEIVED
APR 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03774

3781

CERTIFICATE OF DEATH

Reg. Dist. No.

35

| | | | | | | | |
|--|------------------------------|--|--|---|---|---|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TIMONIUM</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TIMONIUM</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>136 BELFAST RD.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>REBECCA E. KIDD</u> | | | | 4. DATE OF DEATH - <u>APRIL 27 1957</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 12, 1861</u> | 9. AGE (In years last birthday) <u>95</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>BALTO. COUNTY, MD.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>JAMES M. SHEW</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY FISHER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Alice B. Hale</u> Address <u>26 BELFAST RD. TIMONIUM, MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> | | | | | | | |
| 331X DUE TO <u>Hypertension -</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis -</u> <u>Mucous</u> | | | | | | | |
| (c) <u>Arteriosclerosis - Mucous</u> <u>Mucous</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>4/27</u> to <u>4/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/27</u> , 19 <u>57</u> , and that death occurred at <u>4:27 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Bennett A. Stoen</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Lutherville</u> DATE SIGNED <u>4/27/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>BENNETT A. STOEN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>April 30, 1957</u> | | <u>Middleton</u> | | <u>Middleton Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacob Hattenstein</u> | | | | ADDRESS <u>New Freedom Pa.</u> | | 24a. REC'D BY REGISTRAR DATE <u>4/30/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Leicester J. Freedom</u> | | | |

CERTIFICATE OF DEATH

Reg. Div. No.

| | | | | | | | | | | | |
|----------------------------|--|--------------------------|--|--------------------------|--|-----------------------|--|------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | |
| JAMES EARL RAY | | Male | | 35 | | 1922 | | Missouri | | Actor | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | | 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| May 3, 1968 | | 10:00 AM | | St. Louis, Missouri | | Heart Disease | | Natural | | [Signature] | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF CORONER | | 16. SIGNATURE OF JURY | | 17. SIGNATURE OF JUDGE | | 18. SIGNATURE OF CLERK | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. S.

MAY 3 1968

RECEIVED

0377538

3782

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rodgers Forge | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Rodgers Forge Rd. | | d. STREET ADDRESS 209 Rodgers Forge Rd. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First LELAND Middle P. Last KIMBALL | | 4. DATE OF DEATH Month April Day 11 , Year 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 8, 1887 |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Engineer Bld. (Rtd) Railroad | | 10b. KIND OF BUSINESS OR INDUSTRY Mass. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Horace F. Kimball | | 14. MOTHER'S MAIDEN NAME Serena P. Black | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr. Harry P. Kimball - 6211 Haddon Ave. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio vascular DUE TO (c) disease | | INTERVAL BETWEEN ONSET AND DEATH 5 days 10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1952 , 19____, to April 11, 1957 , that I last saw the deceased alive on April 11, 1957 , and that death occurred at 7:15 PM , from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Horace U. Todd M.D. 2108 St Paul St | | | |
| PHYSICIAN'S NAME (Type) Horace U. Todd M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4/13/57 | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem. | 22d. LOCATION (City, town, or county) (State) Woodlawn, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto. | | 24a. REC'D BY REGISTRAR APR 15 1957 | |
| 24b. REGISTRAR'S SIGNATURE Wm. J. Lickner & Sons | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3783

CERTIFICATE OF DEATH

Reg. Dist. No.

32

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PIKESVILLE MD | | | | c. LENGTH OF STAY IN 1b 4 MONTHS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MT. WILSON STATE HOSPITAL | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY 3V01-4 | | | |
| d. STREET ADDRESS 414 S. CHAPEL ST. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First EDITH Middle MAY Last KITTLE | | 4. DATE OF DEATH Month APRIL Day 2 Year 1957 | | 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-13-25 | | 9. AGE (In years last birthday) (31) 32 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME ROBERT L JARMAN | | | | 14. MOTHER'S MAIDEN NAME MARIE JOHNSON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 314-20-8806 | | 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 9 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-29- 19 56 , to 4-2- 19 57 , that I last saw the deceased alive on 4-2- 19 57 , and that death occurred at 9:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE William Newcomer M.D. | | | | PHYSICIAN'S NAME (Type) Wm. Newcomer, M. D. Superintendent Mt. Wilson, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | Apr. 5/57 | | Oak Lawn | | Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1930 Eastern Ave | | | | 24a. REC'D BY REGISTRAR APR 4 1957 | | 24b. REGISTRAR'S SIGNATURE Dorothy Newell | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|------------------------|--|
| STATE OF MARYLAND | | COUNTY OF BALTIMORE | |
| DECEASED | | MAY 1957 | |
| NAME | | EDITH MAY KITTLE | |
| SEX | | FEMALE | |
| RACE | | WHITE | |
| MARRIAGE | | DOMESTIC | |
| OCCUPATION | | HOUSEWIFE | |
| BIRTH | | MAY 1902 | |
| DEATH | | MAY 1957 | |
| PLACE OF BIRTH | | BALTIMORE, MARYLAND | |
| PLACE OF DEATH | | BALTIMORE, MARYLAND | |
| CAUSE OF DEATH | | PULMONARY TUBERCULOSIS | |
| MANNER OF DEATH | | NATURAL | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF MINISTER | |
| SIGNATURE OF CORONER | | SIGNATURE OF JURY | |

BUREAU V. S.

APR 2 1957

RECEIVED

3784

CERTIFICATE OF DEATH

Reg. Dist. No.

0377744

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Lodge Nursing Home 2549 Lodge Forest Drive | | d. STREET ADDRESS 801 North Calvert Street | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Kriener | | 4. DATE OF DEATH Month April Day 21 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 21, 1870 |
| 9. AGE (In years or last birthday) yrs. 87 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Flack | | 14. MOTHER'S MAIDEN NAME Pauline Rose | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic HT Disease DUE TO (c) Stroke Mellitus | | | INTERVAL BETWEEN ONSET AND DEATH 2 mos 10 yrs 10 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4300 | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Nov. 1 , 19 56 , to Apr. 21 , 19 57 , that I last saw the deceased alive on Apr. 21 , 19 57 , and that death occurred at M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James T. Means | | ADDRESS (Street, city or town, state) 520 D. St. | |
| PHYSICIAN'S NAME (Type) James T. Means | | DATE SIGNED 4/22/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 4-24-57 | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR DATE 4/24/57 | 24b. REGISTRAR'S SIGNATURE Laurmond L. Farkley |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

3785

Reg. Dist. No.

03778
39

| | | | | | | | |
|---|------------------------------|---|--------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarm Md. X/ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 347 Glenarm Md. | | | | d. STREET ADDRESS Box 347 Glenarm Md. | | | |
| 3. NAME OF DECEASED (Type or print) K. M. Leonard Lundenklos | | | | 4. DATE OF DEATH Month 4 Day 18 Year 1957 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-14-1878 | | 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer | | 10b. KIND OF BUSINESS OR INDUSTRY farming | | 11. BIRTHPLACE (State or foreign country) BALTIMORE county | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Jacob Lundenklos | | | | 14. MOTHER'S MAIDEN NAME Mary Ryk | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Leonard C. Lundenklos Box 347 Glenarm Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 4-18 , 19 57 , to 4-18 , 19 57 , that I last saw the deceased alive on 4-18 , 19 57 , and that death occurred at 7:00 P. M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Dr. George C. Roberts M.D. | | | | ADDRESS (Street, city or town, state) 4110. Northern Parkway | | | |
| PHYSICIAN'S NAME (Type) | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 4-20-57 | | 22c. NAME OF CEMETERY OR CREMATORY Parkwood | | 22d. LOCATION (City, town, or county) (State) Balto. Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Sassafras Funeral Home | | | | ADDRESS 7401 Belair Rd 6 | | 24a. REC'D BY REGISTRAR APR 22 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Elizabeth Gmouchy | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03770
33

3786

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 36 Butler Road | | | | d. STREET ADDRESS 36 Butler Road | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Henri Last La Porte | | | | 4. DATE OF DEATH Month April Day 13 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 12, 1873 | 9. AGE (In years last birthday) 84 yrs. | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auto. Dealer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | 11. BIRTHPLACE (State or foreign country) U S A | |
| 13. FATHER'S NAME Henery La Porte | | | | 14. MOTHER'S MAIDEN NAME Marie L. Messich | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mary Clark La Porte, Glyndon, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Prostate DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 8 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. None 19 57 | | 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/> None | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 12-19 , 19 44 , to 4-13 , 19 57 , that I last saw the deceased alive on 4-12 , 19 57 , and that death occurred at 1 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown DATE SIGNED _____ ACTUAL SIGNATURE J. D. Caples M.D. _____ PHYSICIAN'S NAME (Type) J. D. CAPLES Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 15/57 | | 22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery | | 22d. LOCATION (City, town, or county) _____ (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons | | | | ADDRESS Reisterstown, Md. | | 24a. REC'D BY REGISTRAR DATE 4-15-57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Mary B Eline | | | |

BUREAU V. S.

APR 16 1957

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar proper for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03780

3787

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b <u>2 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3401-4</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | d. STREET ADDRESS <u>323 S. Parrish Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Leahy</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>19 57</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 1, 1882</u> | |
| 9. AGE (In years last birthday) yrs. <u>74</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown (retired)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>John Joseph Leahy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> | | | | 16. SOCIAL SECURITY NO. <u>unknown</u> | | 17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>March 29</u> , 19 <u>57</u> , to <u>April 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 1</u> , 19 <u>57</u> , and that death occurred at <u>12:55 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D. <u>SPRING GROVE STATE HOSPITAL 4-1-57</u> PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> <u>Catonsville 28, Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>4/4/57</u> | | <u>New Cathedral</u> | | <u>Balto. 29. Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wible</u> | | | | ADDRESS <u>4101 Edmondson</u> | | 24a. REC'D BY REGISTRAR DATE <u>APR 2 '57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>W. Beach</u> | | | | | | | |

APR 3 1957

RECEIVED

3788

CERTIFICATE OF DEATH

03781 38

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Towson | | c. LENGTH OF STAY IN TB 1 Yr. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home | | d. STREET ADDRESS 636 Murdock Road | |
| 3. NAME OF DECEASED (Type or print) First GEORGE Middle R. Last LEPHARDT | | 4. DATE OF DEATH Month APRIL Day 12 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 17, 1879 |
| 9. AGE (In years lost birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mailman | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Postal Ser. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Christopher Lephardt | | 14. MOTHER'S MAIDEN NAME Catherine Rehbein | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Miss Rosalie M. Lephardt | | Address -636 Murdock Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mel. DUE TO (c) Atherosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from JUNE 10 , 19 45 , to April 12 , 19 57 , that I last saw the deceased alive on April 12 , 19 57 , and that death occurred at 1 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Laurence C. Post | | ADDRESS (Street, city or town, state) 6805 York Rd Baltimore 12 Md. | |
| DATE SIGNED APR 15 1957 | | DATE SIGNED APR 15 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/15/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran | | ADDRESS 3000 E. Baltimore St. | |
| 24a. REC'D BY REGISTRAR APR 15 1957 | | 24b. REGISTRAR'S SIGNATURE Metel Gray | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

Belgium

Male

March 13, 1979

85

BUREAU V. S.

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03782

3789

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 3yr8mth10dys | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frankville, Md. (Franklinville) | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | d. STREET ADDRESS Frankville, Maryland | | | |
| 3. NAME OF DECEASED (Type or print) First Carrie Middle Lewis Last Lewis | | | | 4. DATE OF DEATH Month 4 Day 28 Year 19 57 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 8, 1878 | |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months 4 Days 28 Hours 19 Min. 57 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME James W. Carroll | | | | 14. MOTHER'S MAIDEN NAME -unknown Galloway | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioscl. Cardio Vasc. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis gen. severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 22, 19 57 to 4 28 , 19 57 , that I last saw the deceased alive on 4 28 , 19 57 , and that death occurred at 1:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Stella Wachslar | | | | M.D. SPRING GROVE STATE HOSPITAL | | | |
| PHYSICIAN'S NAME (Type) STELLA WACHSLER | | | | Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr 30, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Franklinville Presbyterian | | 22d. LOCATION (City, town, or county) (State) Franklinville, Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son | | | | ADDRESS Abingdon, Md., | | 24a. REC'D BY REGISTRAR DATE MAY 9 57 | |
| 24b. REGISTRAR'S SIGNATURE Quelovich | | | | | | | |

CERTIFICATE OF DEATH

MAXIMAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Reg. Dist. No.

| | | | | | |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED JAMES V. GILBERT | | 2. SEX Male | | 3. AGE 45 | |
| 4. DATE OF DEATH May 3, 1957 | | 5. TIME OF DEATH 10:30 AM | | 6. PLACE OF DEATH Home | |
| 7. CAUSE OF DEATH Myocardial Infarction | | 8. MANNER OF DEATH Natural | | 9. SIGNATURE OF PHYSICIAN J. H. Smith | |
| 10. SIGNATURE OF REGISTRAR J. H. Smith | | 11. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith | | 12. SIGNATURE OF DECEASED J. H. Smith | |
| 13. SIGNATURE OF DECEASED J. H. Smith | | 14. SIGNATURE OF DECEASED J. H. Smith | | 15. SIGNATURE OF DECEASED J. H. Smith | |
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| 97. SIGNATURE OF DECEASED J. H. Smith | | 98. SIGNATURE OF DECEASED J. H. Smith | | 99. SIGNATURE OF DECEASED J. H. Smith | |
| 100. SIGNATURE OF DECEASED J. H. Smith | | 101. SIGNATURE OF DECEASED J. H. Smith | | 102. SIGNATURE OF DECEASED J. H. Smith | |

BUREAU V. 5

MAY 3 1957

RECEIVED

3790

CERTIFICATE OF DEATH

Reg. Dist. No. 38

| | | | | | | | |
|--|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore -18 3401-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Home | | | | d. STREET ADDRESS 3120 Harford Rd. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) JANE First DIAMOND Middle LEWIS Last | | | | 4. DATE OF DEATH April 25, 1957 Month Day Year | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 17, 1878 | 9. AGE (In years last birthday) 78 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pittsburgh Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME John Getty | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Gerst | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Mrs. Martha Gescheider | | | | Address 3120 Harford Rd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Brochypneumonia DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension (c) 1 year 5 years INTERVAL BETWEEN ONSET AND DEATH 1 year 5 years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Feb 1, 1954 , to Apr 25, 1957 , that I last saw the deceased alive on Apr 24, 1957 , and that death occurred at 8:45 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William F. Pearce M.D. | | | | ADDRESS (Street, city or town, state) 2105 N. Charles St Baltimore 18 Md | | | |
| PHYSICIAN'S NAME (Type) | | | | DATE SIGNED 4/25/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 29, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Uniondale Cemetery | | 22d. LOCATION (City, town, or county) (State) Pittsburgh Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. | | | | ADDRESS North & Broadway | | | |
| 24a. REC'D BY REGISTRAR DATE 4/24/57 | | | | 24b. REGISTRAR'S SIGNATURE Dw A M. Bacon | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 25 1957

RECEIVED

3791 CERTIFICATE OF DEATH

Reg. Dist. No.

33

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tollgate c. LENGTH OF STAY IN 1b 6 Mths. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 Ritters Lane | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS 104 Ritters Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CHARLES S. LLOYD | | 4. DATE OF DEATH Month Day Year April 1, 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-22-1880 |
| 9. AGE (In years lost birthday) 77 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Lloyd | | 14. MOTHER'S MAIDEN NAME Sarah Oaks | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 217-03-2650 | |
| 17. INFORMANT Edward L. Lloyd, Tollgate, Md. | | Address | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis Agitans | | INTERVAL BETWEEN ONSET AND DEATH 15 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | | | | |
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| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|--|---|---|--|--|

21. I certify that I attended the deceased from **Mar 14**, 19**56**, to **Mar 30**, 19**57**, that I last saw the deceased alive on **Mar 30**, 19**57**, and that death occurred at **10:30 AM**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **Pikesville 8, Md.** DATE SIGNED **April 2, 1957**

ACTUAL SIGNATURE **Waverly S. Green, Jr.** M.D. **Waverly S. Green, Jr. M.D.**

PHYSICIAN'S NAME (Type)

| | | | |
|--|------------------------------------|---|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4-3-57 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery | 22d. LOCATION (City, town, or county) (State) Randallstown, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Marshall | | 24a. REC'D BY REGISTRAR DATE APR 3 1957 | 24b. REGISTRAR'S SIGNATURE Mary Elise |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 3 1957

RECEIVED

RECEIVED
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APR 3 1957

3792

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
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| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine, Maryland</u> 16 x 12 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u> | | d. STREET ADDRESS <u>Route #2 - Box 94A</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Susanna</u> Middle <u>Mae</u> Last <u>Loveday</u> | | 4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>19 57</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 17, 1876</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u> | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>Noah Gilmore</u> | |
| 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>unknown</u> | | 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Arteriosclerosis, generalized and severe</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>April 6, 1957</u> , to <u>April 12, 1957</u> , that I last saw the deceased alive on <u>April 12, 1957</u> , and that death occurred at <u>5:10 p.m.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Stella Wachslar</u> | | ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> | |
| PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u> | | DATE SIGNED <u>Catonsville 28, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 22b. DATE THEREOF <u>4-13-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Wilkinsburg</u> | 22d. LOCATION (City, town, or county) (State) <u>Wilkinsburg, Pa.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u> | | 24a. REC'D BY REGISTRAR DATE <u>APR 15 '57</u> | 24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. PLACE OF BIRTH | | 5. DATE OF BIRTH | | 6. PLACE OF DEATH | |
| 7. OCCUPATION | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | |
| 10. SIGNATURE OF PHYSICIAN | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF WITNESSES | |
| 13. DATE OF DEATH | | 14. TIME OF DEATH | | 15. PLACE OF INTERMENT | |
| 16. NAME OF FUNERAL HOME | | 17. NAME OF CEMETERY | | 18. NAME OF MINISTER | |
| 19. NAME OF CLERGYMAN | | 20. NAME OF CHURCH | | 21. NAME OF SOCIETY | |
| 22. NAME OF SOCIETY | | 23. NAME OF SOCIETY | | 24. NAME OF SOCIETY | |
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| 85. NAME OF SOCIETY | | 86. NAME OF SOCIETY | | 87. NAME OF SOCIETY | |
| 88. NAME OF SOCIETY | | 89. NAME OF SOCIETY | | 90. NAME OF SOCIETY | |
| 91. NAME OF SOCIETY | | 92. NAME OF SOCIETY | | 93. NAME OF SOCIETY | |
| 94. NAME OF SOCIETY | | 95. NAME OF SOCIETY | | 96. NAME OF SOCIETY | |
| 97. NAME OF SOCIETY | | 98. NAME OF SOCIETY | | 99. NAME OF SOCIETY | |
| 100. NAME OF SOCIETY | | 101. NAME OF SOCIETY | | 102. NAME OF SOCIETY | |

BUREAU V. 3

APR 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03786

3793

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u> | | | | c. LENGTH OF STAY IN 1b <u>3 weeks</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u> | | | | d. STREET ADDRESS <u>Lake Drive Apts</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>ADOLPH</u> First <u>-HOWENSTEIN</u> Middle <u>Lost</u> 4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1957</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Jewelry Store</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Turkey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Herman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Not known</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Morton Rosen - Lake Drive Apts</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19- p. m. | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>August 16, 1956</u> to <u>March 16, 1957</u> , that I last saw the deceased alive on <u>March 16, 1957</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Samuel Whittehouse</u> M.D. <u>2933 N. Charles St.</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <u>SAMUEL WHITEHOUSE</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4-14-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Gutter Place</u> | | | | 24a. REC'D BY REGISTRAR <u>APR 18 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Wick</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 16 1957

RECEIVED

3794

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|-------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | | | c. LENGTH OF STAY IN 1b 4 months | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE ST. Hosp. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last DOROTHY D. LYONS | | | | 4. DATE OF DEATH Month Day Year April 18 1957 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/3/1904 | 9. AGE (In years last birthday) 52 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) NEW YORK | |
| 13. FATHER'S NAME CHARLES WHITING | | | | 14. MOTHER'S MAIDEN NAME ABIGAIL BENTON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) — | | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Hospital records Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease DUE TO (c) — | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day year |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 23, 1956 , to April 18, 1957 , that I last saw the deceased alive on April 18, 1957 , and that death occurred at 6:45 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Charles Ward | | | | ADDRESS (street, city or town, state) Spring Grove Hosp., Catonsville 28, Md. | | | |
| PHYSICIAN'S NAME (Type) CHARLES WARD | | | | DATE SIGNED 4/18/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/22/57 | | 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem. | | 22d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto. | | | | 24a. REC'D BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE W. Lickner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 24 57

CERTIFICATE OF DEATH

State of Maryland

| | | | | | |
|--|--|---|--|--|--|
| 1. NAME OF DECEASED <i>John A. Smith</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>65</i> | |
| 4. PLACE OF BIRTH <i>Washington, D.C.</i> | | 5. DATE OF BIRTH <i>Jan 15, 1892</i> | | 6. PLACE OF DEATH <i>Washington, D.C.</i> | |
| 7. CAUSE OF DEATH <i>Heart Disease</i> | | 8. MANNER OF DEATH <i>Natural</i> | | 9. TIME OF DEATH <i>10:30 AM</i> | |
| 10. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 11. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 12. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 13. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 14. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 15. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 16. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 17. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 18. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 19. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 20. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 21. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 22. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 23. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 24. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 25. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 26. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 27. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 28. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 29. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 30. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 31. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 32. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 33. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 34. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 35. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 36. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 37. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 38. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 39. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 40. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 41. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 42. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 43. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 44. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 45. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 46. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 47. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 48. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 49. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 50. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 51. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 52. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 53. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 54. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 55. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 56. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 57. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 58. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 59. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 60. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 61. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 62. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 63. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 64. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 65. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 66. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 67. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 68. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 69. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 70. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 71. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 72. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 73. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 74. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 75. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 76. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 77. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 78. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 79. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 80. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 81. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 82. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 83. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 84. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 85. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 86. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 87. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 88. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 89. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 90. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 91. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 92. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 93. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 94. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 95. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 96. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 97. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 98. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 99. SIGNATURE OF DECEASED <i>John A. Smith</i> | |
| 100. SIGNATURE OF DECEASED <i>John A. Smith</i> | | 101. SIGNATURE OF WITNESS <i>John A. Smith</i> | | 102. SIGNATURE OF DECEASED <i>John A. Smith</i> | |

BUREAU V. S.

APR 24 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3795

Reg. Dist. No.

03788
38

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON | | | | c. LENGTH OF STAY IN 1b 2 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON CONVAL. HOME | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First SOPHIE Middle MANGAN Last MANGAN | | | | 4. DATE OF DEATH Month APRIL Day 8 Year 19 57 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JULY-30-1894 | |
| 9. AGE (In years last birthday) 62 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) PHILA - PA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. VALENTINE - FORGENG | | | |
| 14. MOTHER'S MAIDEN NAME CATHERINE - OVERHAUSER | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. NONE | | | | 17. INFORMANT JOHN-J-DOUGHERTY - 17 CROFTLEY RD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensative Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) PHILADELPHIA | | | | 20g. (County) PA | | 20h. (State) PA | |
| 21. I certify that I attended the deceased from April 8 , 19 57 , to April 8 , 19 57 , that I last saw the deceased alive on April 8 , 19 57 , and that death occurred at 7:40 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Laurence C. Tosh | | | | M.D. 6805 York Rd Baltimore, Md. | | | |
| PHYSICIAN'S NAME (Type) LAURENCE C. TOSH | | | | DATE SIGNED April 12, 1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF APRIL-13-1957 | | 22c. NAME OF CEMETERY OR CREMATORY HOLY SEPULCHUR | | 22d. LOCATION (City, town, or county) (State) PHILADELPHIA - PA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm COOK-INC - BALTIMORE-MD | | | | 24a. REC'D BY REGISTRAR DATE 4/9/57 | | 24b. REGISTRAR'S SIGNATURE Mabel Krays | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

APR 10 1957

RECEIVED

3796

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3 Vol-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS 5603 Wayne Avenue | |
| 3. NAME OF DECEASED (Type or print) Annie Cecelia Watts McCalley | | 4. DATE OF DEATH Month April Day 19 Year 57 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 29, 1867 |
| 9. AGE (In years last birthday) 89 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY housework | |
| 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME T. Watts William | | 14. MOTHER'S MAIDEN NAME Mary Trazzare | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility - Senile brain disease | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) Balto., Md. | | (County) (State) | |
| 21. I certify that I attended the deceased from April 10, 1957 , to April 19, 1957 , that I last saw the deceased alive on April 19, 1957 , and that death occurred at 7:40a M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stella Wachslor M.D. | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-19-57 | |
| PHYSICIAN'S NAME (Type) Stella Wachslor, M. D. | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4/21/57 | 22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem. | 22d. LOCATION (City, town, or county) (State) Balto., Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hecker & Sons - Balto. | | 24a. REC'D BY REGISTRAR DATE APR 24 '57 | 24b. REGISTRAR'S SIGNATURE W. Beach |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Race | |
| 4. Date of birth | | 5. Date of death | | 6. Place of death | |
| 7. Cause of death | | 8. Duration of illness | | 9. Name of physician | |
| 10. Name of informant | | 11. Signature of informant | | 12. Signature of physician | |
| 13. Name of funeral home | | 14. Name of cemetery | | 15. Name of burial place | |
| 16. Name of next of kin | | 17. Name of executor | | 18. Name of administrator | |
| 19. Name of executor | | 20. Name of administrator | | 21. Name of executor | |
| 22. Name of administrator | | 23. Name of executor | | 24. Name of administrator | |
| 25. Name of executor | | 26. Name of administrator | | 27. Name of executor | |
| 28. Name of administrator | | 29. Name of executor | | 30. Name of administrator | |
| 31. Name of executor | | 32. Name of administrator | | 33. Name of executor | |
| 34. Name of administrator | | 35. Name of executor | | 36. Name of administrator | |
| 37. Name of executor | | 38. Name of administrator | | 39. Name of executor | |
| 40. Name of administrator | | 41. Name of executor | | 42. Name of administrator | |
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| 46. Name of administrator | | 47. Name of executor | | 48. Name of administrator | |
| 49. Name of executor | | 50. Name of administrator | | 51. Name of executor | |
| 52. Name of administrator | | 53. Name of executor | | 54. Name of administrator | |
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| 67. Name of executor | | 68. Name of administrator | | 69. Name of executor | |
| 70. Name of administrator | | 71. Name of executor | | 72. Name of administrator | |
| 73. Name of executor | | 74. Name of administrator | | 75. Name of executor | |
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| 79. Name of executor | | 80. Name of administrator | | 81. Name of executor | |
| 82. Name of administrator | | 83. Name of executor | | 84. Name of administrator | |
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| 88. Name of administrator | | 89. Name of executor | | 90. Name of administrator | |
| 91. Name of executor | | 92. Name of administrator | | 93. Name of executor | |
| 94. Name of administrator | | 95. Name of executor | | 96. Name of administrator | |
| 97. Name of executor | | 98. Name of administrator | | 99. Name of executor | |
| 100. Name of administrator | | 101. Name of executor | | 102. Name of administrator | |

BUREAU V. 1

APR 24 1957

RECEIVED

3797

CERTIFICATE OF DEATH

03790

30

Items 10, 11, 13, 14, 15, & 16 Fill in 12, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN 1b <u>56 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u> | | e. STREET ADDRESS <u>315 Ingleside Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Joseph</u> First Middle Last <u>McDonald</u> | | 4. DATE OF DEATH <u>April</u> Month Day Year <u>21</u> <u>19 57</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-13-64</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown Private</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u> | 9. AGE (In years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles McDonald</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Baltimore County Welfare Board</u> | | Address <u>209 Washington, Towson, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>April 17</u> , 19 <u>57</u> , to <u>April 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 21</u> , 19 <u>57</u> , and that death occurred at <u>5:15</u> p.m., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Stella Wachslar</u> | | ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>4-22-57</u> | |
| PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> | | <u>Catonsville 28, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>4/25/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balto 17 Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>4-24-57</u> 24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--------------------|--|--------------------|--|----------------------|--|-----------------------|--|----------------------|--|------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1922 | | MOBILE, ALABAMA | |
| RESIDENCE | | OCCUPATION | | EDUCATION | | MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | |
| MEMPHIS, TENNESSEE | | ATTORNEY | | HIGH SCHOOL | | MARRIED | | 4/4/68 | | MEMPHIS, TENNESSEE | |
| CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE OF DEATH | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | |
| HEART DISEASE | | NATURAL | | 1 | | | | | | | |
| DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| 4/4/68 | | MEMPHIS, TENNESSEE | | 4/4/68 | | MEMPHIS, TENNESSEE | | 4/4/68 | | MEMPHIS, TENNESSEE | |

BUREAU V. 2

APR 05 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3798

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03791

Reg. Dist. No. 45

| | | | | | | | |
|---|----------------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 405 Riverside Drive ESSEX 21</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bowley's Qt. Rd. and Glenwood Rd.</u> | | | | d. STREET ADDRESS <u>405 Riverside Drive</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>Merle</u> Last <u>McNeel</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-3-1914</u> | | 9. AGE (In years last birthday) <u>42</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Foreman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ind.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas McNeel</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Keasling</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>312-14-9089</u> | | 17. INFORMANT <u>William Morley</u> Address <u>Same</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound - Head - Suicide</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 Sec</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Jack E Collins</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>JACK E COLLINS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u> | | 22b. DATE THEREOF <u>4/14/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Pine Bluff</u> | | 22d. LOCATION (City, town, or county) (State) <u>Clay Co. Miss.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James J Brudzinski</u> | | | | ADDRESS <u>1407 Eastern Ave.</u> | | 24a. REC'D BY REGISTRAR DATE <u>4/14/57</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Earl Hurley</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 81

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3799

CERTIFICATE OF DEATH

Reg. Dist. No.

03792
28

| | | | | | | | |
|---|------------------------------|---|---|--|---|---|--------------------------------------|
| 1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | c. LENGTH OF STAY IN 1b LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 12 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 218 DUNKIRK ROAD | | | | d. STREET ADDRESS 218 DUNKIRK ROAD | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE MEISER | | | | 4. DATE OF DEATH Month Day Year APRIL 13, 1957 19 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH OCT. 19, 1886 | | 9. AGE (In years last birthday) yrs. 70 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MD. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME FREDERICK LANG | | | | 14. MOTHER'S MAIDEN NAME WILHELMINA MAGAW | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 212 07 5801 | | 17. INFORMANT Address MRS HAROLD BUCHANAN 218 DUNKIRK ROAD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE COLON 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. NONE 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from November , 19 55 , to April 13th , 19 57 , that I last saw the deceased alive on April 13th , 19 57 , and that death occurred at 3:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. S. Chalfant M.D. M.D. 6210 York Road, Baltimore, 12, MD. PHYSICIAN'S NAME (Type) A. S. Chalfant | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF APRIL 15, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY | | 22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD. <i>Henry Sander</i> | | | | 24a. REC'D BY REGISTRAR DATE 4-16-57 | | 24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i> | |

BUREAU V. A.

RECEIVED

APR 16 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03793

3800

CERTIFICATE OF DEATH

Reg. Dist. No.

38

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8643 Rock Oak Road | | | | d. STREET ADDRESS 1 8643 Rock Oak Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Thomas Middle K. G. Last Milke | | | | 4. DATE OF DEATH Month April Day 28 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 29, 1879 | |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME Henry Milke | | | | 14. MOTHER'S MAIDEN NAME Eliza Mimney | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-03-9855 | | 17. INFORMANT John W. Milke Address 337 Fonthill Avenue | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial Infarction DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 months | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/2, 1956 to 4/28, 1957 , that I last saw the deceased alive on 4/28, 1957 , and that death occurred at 4:20 M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. Meredith Smith M.D. | | | | ADDRESS (Street, city or town, state) 6305 The Armada | | DATE SIGNED 4/29/57 | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 1, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Lorrain Park | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St. | | | | 24a. REC'D BY REGISTRAR DATE 4/30/57 | | 24b. REGISTRAR'S SIGNATURE Mabel Gray | |

CERTIFICATE OF DEATH

38-10

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

MAY 1 1957

RECEIVED

3801

CERTIFICATE OF DEATH

03794

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOUNT WILSON | | | | c. LENGTH OF STAY IN 1b 3 1/2 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MOUNT WILSON STATE | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22 53 | | | |
| f. STREET ADDRESS 821 MILDRED AVENUE | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First CARRIE Middle MAUD Last MURPHY. | | | | 4. DATE OF DEATH Month 4 Day 10 Year 1957 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 8-28-02 | |
| 9. AGE (In years last birthday) 54 yrs. | | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | | IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME CALEB SAWYER | | | | 14. MOTHER'S MAIDEN NAME MARY SWANE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 225-12-7042 | | 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 9-1-1953 , to 4-10-1957 , that I last saw the deceased alive on 4-10-1957 , and that death occurred at 9 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 4-10-57 | | | | | | | |
| ACTUAL SIGNATURE William Newcomer M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent | | | | Mt. Wilson, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 22b. DATE THEREOF 4-11-57 | | 22c. NAME OF CEMETERY OR CREMATORY Norfolk | | 22d. LOCATION (City, town, or county) (State) Norfolk VA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc | | | | ADDRESS 1217 St. Paul | | 24a. REC'D BY REGISTRAR DATE 4/12/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Sonahy Newell | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

3892 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-------------------|---|---------------------|--|-----------------|---|------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Baltimore</u> | | MARYLAND | | STATE <u>MARYLAND</u> | | COUNTY <u>Hagerstown</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Rural: Towson</u> | | <u>3 mo 14 days</u> | | TOWN <u>ABERDEEN 12312</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | Towson 4, Maryland | | STREET ADDRESS (If rural give location) <u>476 BELAIR ST.</u> | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE OF DEATH: | | | |
| (First) <u>FULLER</u> | | (Middle) <u>N</u> | | (Last) <u>NANCE</u> | | (Year) <u>1957</u> | |
| (Type or Print) | | | | | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>MALE</u> | <u>WHITE</u> | <u>WIDOWED</u> | <u>DEC. 29 1881</u> | <u>75</u> yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Physician</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Medical</u> | | 11. BIRTHPLACE (State or foreign country): <u>Union County - N. Carolina U.S.A.</u> | |
| 13. FATHER'S NAME: <u>JAMES SILAS NANCE</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>MARTHA DIANA EDWARDS</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> | | 16. SOCIAL SECURITY No.: <u>NONE</u> | | 17. INFORMANT & ADDRESS: <u>Personal History Hospital Records, Eudowood Sanatorium</u> | | | |

| | | |
|---|--|----------------------------------|
| 18. MEDICAL CERTIFICATION | | Interval Between Onset And Death |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| Immediate cause (a) <u>Pulmonary Tuberculosis</u> | | <u>4 1/2 mo</u> |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>DUE TO</u> | | |
| (c) | | |

| | | | |
|---|--|---|--|
| 11. OTHER SIGNIFICANT CONDITIONS | | 20. AUTOPSY ? | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDINGS OF OPERATION | |
| 21. ACCIDENT (Specify) | | PLACE (Home, farm, factory, street, office bldg., etc.) | |
| SUICIDE | | (CITY OR TOWN) | |
| HOMICIDE | | (COUNTY) | |
| TIME (Month) (Day) (Year) (Hour) | | (STATE) | |
| OF INJURY | | INJURY OCCURRED | |
| m. | | While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| | | HOW DID INJURY OCCUR ? | |

22. I hereby certify that I attended the deceased from Dec. 19 56 to April 29 57 that I last saw the deceased alive on April 19 57, and that death occurred at 4:15 P.M. from the causes and on the date stated above.

| | | | | | |
|--|--|---|--|---|--|
| SIGNATURE | | ADDRESS | | DATE SIGNED | |
| <u>William B. Kloss</u> | | <u>Eudowood Sanatorium - Towson 4, Maryland</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| <u>Burial</u> | | <u>April 6, 1957</u> | | <u>Druid Ridge Cemetery Pikesville Balt. Co. Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | |
| <u>4/13/57</u> | | <u>W. H. Hedrick</u> | | <u>Henry W. Jenkins & Sons Co. 4905 York Road</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

APR 10 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 TIMONIUM</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>3 Cinder Road</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Nona</u> Middle <u>Peterson</u> Last <u>Peterson</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1957</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 21, 1884</u> |
| 9. AGE (In years last birthday) <u>72 1/2</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>THOMAS WHITE</u> | | 14. MOTHER'S MAIDEN NAME <u>REBECCA TOLSON</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Family Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept. 9, 1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Towson, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons</u> | | ADDRESS <u>Towson, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>APR 11 '57</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|------------|--|----------------|--|-----------------|--|-----------------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| HARRY J. HARRIS | | 45 | | M | | W | | APR 11 1957 | | BOSTON, MASS. | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF EXAMINER | | TITLE | |
| 100 N. ST. | | LABORER | | HEART DISEASE | | NATURAL | | [Signature] | | M.D. | |
| CITY | | STATE | | CITY | | STATE | | CITY | | STATE | |
| BOSTON | | MASS. | | BOSTON | | MASS. | | BOSTON | | MASS. | |

BUREAU V. A.

APR 11 1957

RECEIVED

3804

CERTIFICATE OF DEATH

Reg. Dist. No.

31

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn | | | | c. LENGTH OF STAY IN 1b 4 Yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1930 Hillcrest Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Margaret) First Middle Last Margaretta Powers | | | | 4. DATE OF DEATH Month Day Year April 15, 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 16, 1875 | 9. AGE (In years last birthday) 82 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife | | | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME John Keller | | | | 14. MOTHER'S MAIDEN NAME Martha January | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT John H. Powers, 3rd. 1923 Hillcrest Rd. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 147 antepartum C.V. Disease DUE TO (c) Senility | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from June 1955 , 19____, to Apr 15, 1957 , that I last saw the deceased alive on Apr 15, 1957 , and that death occurred at 11:00 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE M. Paul Byerly M.D. | | | | ADDRESS (Street, city or town, state) 3033 W North A | | | |
| PHYSICIAN'S NAME (Type) M. Paul Byerly | | | | DATE SIGNED 8/10/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-18-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | 22d. LOCATION (City, town, or county) (State) Pikesville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward Strong | | | | ADDRESS 307 W. North Ave | | 24a. REC'D BY REGISTRAR APR 18 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE J. H. Martin | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03798

3805

CERTIFICATE OF DEATH

Reg. Dist. No. 33

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring (Rural)</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring - Rural</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u> | | d. STREET ADDRESS <u>✓</u> | |
| 3. NAME OF DECEASED (Type or print) <u>NETTIE - L - PRICE</u> | | 4. DATE OF DEATH <u>April 15 - 1957</u> | |
| 5. SEX <u>H</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>unknown</u> |
| 9. AGE (In years last birthday) <u>79</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Price</u> | | 14. MOTHER'S MAIDEN NAME <u>Luciana Klinedinst</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-22-8851</u> | |
| 17. INFORMANT <u>Walter Boring, Boring Md</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>Decubitus Ulcers</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>5 yr</u> <u>1 month</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 12 1957</u> to <u>April 15 1957</u> , that I last saw the deceased alive on <u>April 12 1957</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W H Foard</u> | | ADDRESS (Street, city or town, state) <u>Manchester Md.</u> DATE SIGNED <u>4/15/57</u> | |
| PHYSICIAN'S NAME (Type) <u>W.H. Foard</u> | | <u>Manchester, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>Apr 17/57</u> | <u>Green Ridge</u> | <u>Balto Co Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR | |
| <u>Edw & Gtpton - Hampstead Md</u> | | DATE <u>4-16-57</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE | |
| | | <u>Mary B. Elmer</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03799

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3896

Reg. Dist. No.

| | | | | | | | | |
|---|--|---|--|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | c. LENGTH OF STAY IN 1b 16 1/2 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital | | | | d. STREET ADDRESS 1533 Linden Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Mollie Middle Hibb Last Prissman | | | | 4. DATE OF DEATH Month April Day 26 Year 19 57 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 11, 1873 | | |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Moritz Hibb | | | | 14. MOTHER'S MAIDEN NAME Hannah Lehman | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT RECORDS: Spring Grove State Hospital | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardiovascular disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days years | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Geo. S. M. Kieffer M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) GEO. S. M. KIEFFER | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-29-57 | | 22c. NAME OF CEMETERY OR CREMATORY Oheb Shalom Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin David R. Martin, 1902 Euter Place | | | | 24a. REC'D BY REGISTRAR APR 30 57 DATE | | 24b. REGISTRAR'S SIGNATURE W. J. Leach | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—BIRMINGHAM
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17. 11. 1911

RECEIVED
APR 30 1957
BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 9, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100
3897
CERTIFICATE OF DEATH

03800

Reg. Dist. No.

21

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRANITE</u> | | | | c. LENGTH OF STAY IN 1b <u>40 YRS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>OLD COURT RD</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>OLIVER CHESTER KUTNEY</u> | | | | 4. DATE OF DEATH <u>APRIL 17 1957</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JUNE 28-1877</u> | |
| 9. AGE (In years last birthday) <u>80 YRS</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STONE-CUTTER</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NO</u> | | 17. INFORMANT <u>MRS OLIVER-LANDSDOWNE - MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC NEPHRITIS & TERMINAL</u> <u>442X</u> DUE TO (b) <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>HYPERTENSIVE C.V. DISEASE & ARTERIAL</u> <u>15 YRS</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>MAR 1</u> , 1957, to <u>APRIL 17</u> , 1957, that I last saw the deceased alive on <u>APRIL 17</u> , 1957, and that death occurred at <u>M</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>3601 CLIFMAR RD BALTO MD</u> | | | |
| DATE SIGNED <u>4/17/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>April 20, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u> | | 22d. LOCATION (City, town, or county) (State) <u>Randlestown MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd</u> | | | | 24a. REC'D BY REGISTRAR <u>APR 22 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Dr. Jm. E. M...</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Reg. No. 100

| | | | |
|--|--|--|--|
| NAME OF DECEASED <i>WILLIAM J. WILSON</i> | | AGE <i>45</i> | |
| SEX <i>MALE</i> | | RACE <i>WHITE</i> | |
| DATE OF BIRTH <i>1892</i> | | PLACE OF BIRTH <i>NEW YORK</i> | |
| DATE OF DEATH <i>1957</i> | | PLACE OF DEATH <i>BALTIMORE</i> | |
| CAUSE OF DEATH <i>HEART DISEASE</i> | | MANNER OF DEATH <i>NATURAL</i> | |
| SIGNATURE OF PHYSICIAN <i>WILLIAM J. WILSON</i> | | SIGNATURE OF REGISTRAR <i>WILLIAM J. WILSON</i> | |
| DATE OF SIGNATURE <i>1957</i> | | DATE OF SIGNATURE <i>1957</i> | |

BUREAU V. 5

APR 22 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 45

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>602 New Jersey Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Harold Vernon Raver</u> | | 4. DATE OF DEATH Month Day Year <u>April 5, 19 57</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 3, 1907</u> |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Raver</u> | | 14. MOTHER'S MAIDEN NAME <u>Pearl Appleton</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Will</u> | | 16. SOCIAL SECURITY NO. <u>216-01-5939</u> | |
| 17. INFORMANT <u>Margert Bayer Raver</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peptic Ulcer & Massive</u> <u>322.2</u> DUE TO <u>Gastric Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Alcoholism</u> (b) <u>Alcoholism</u> (c) <u>Alcoholism</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>M.B. Davis</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/8/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>4/8/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Earl Hume</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3899

CERTIFICATE OF DEATH

0380244

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3v01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 719 DOLPHIN STREET | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle (NMI) Last RAWLINGS | | 4. DATE OF DEATH Month APRIL Day 20 Year 1957 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-7-96 |
| 9. AGE (In years last birthday) yrs. 61 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR | | 10b. KIND OF BUSINESS OR INDUSTRY OFFICE BUILDING | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN RAWLINGS | | 14. MOTHER'S MAIDEN NAME CARRIE SMITH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1 | | 16. SOCIAL SECURITY NO. UNKNOWN | |
| 17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 WEEK UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X PULMONARY TUBERCULOSIS | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from FEB. 12 , 19 57 , to APRIL 20 , 19 57 , and that death occurred at 3:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 4/21/57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D. M.D. VAH, FORT HOWARD, MARYLAND | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-24-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | 24a. REC'D BY REGISTRAR DATE APR 24 1957 | |
| 24b. REGISTRAR'S SIGNATURE Lawson L. Fairley | | | |

MRS. HELEN A. HOLLAND FUNERAL HOME, 1631 Druid Hill Ave.
Baltimore, Md.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|-----------------------------|--|--|--|------------------------------|--|---------------------------------------|--|----------------------------|--|
| NAME OF DECEASED MATTHEW | | AGE 37 | | SEX M | | RACE W | | DATE OF DEATH 1-1-55 | | PLACE OF DEATH HOSPITAL | |
| RESIDENCE 110 JOHNS ST | | CITY BALTIMORE | | COUNTY BALTIMORE | | STATE MD | | ZIP CODE 21201 | | HOSPITAL JOHNS HOPKINS | |
| DATE OF BIRTH 1-1-18 | | PLACE OF BIRTH BALTIMORE | | CITY BALTIMORE | | COUNTY BALTIMORE | | STATE MD | | ZIP CODE 21201 | |
| MARRIAGE MARRIED | | DATE OF MARRIAGE 1-1-55 | | PLACE OF MARRIAGE BALTIMORE | | CITY BALTIMORE | | COUNTY BALTIMORE | | STATE MD | |
| CAUSE OF DEATH HEART DISEASE | | MANNER OF DEATH NATURAL | | IMMEDIATE CAUSE CORONARY THROMBOSIS | | MIDDLE CAUSE HYPERTENSION | | FUNDAMENTAL CAUSE ARTERIOSCLEROSIS | | OTHER CAUSE NONE | |
| SIGNATURE OF PHYSICIAN J. H. HARRIS | | DATE 1-1-55 | | SIGNATURE OF REGISTRAR J. H. HARRIS | | DATE 1-1-55 | | SIGNATURE OF WITNESS J. H. HARRIS | | DATE 1-1-55 | |

BUREAU V. 8

APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03803 41

3810

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2500 Pac Lane | | d. STREET ADDRESS 2500 Pac Lane | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First LILLIAN Middle E. Last REHBEIN | | 4. DATE OF DEATH Month April Day 3 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 22, 1904 |
| 9. AGE (In years last birthday) 52 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Brown | | 14. MOTHER'S MAIDEN NAME Anna B. Parr | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Robert L. Rehbein | | Address 2500 Pac Lane | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 years | | | INTERVAL BETWEEN ONSET AND DEATH 5 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 3:1 , 19 57 , to 4:3 , 19 57 , that I last saw the deceased alive on 4:2 , 19 57 , and that death occurred at 7A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE R. G. Windsor | | ADDRESS (Street, city or town, state) 5200 St. Sp R 19 | |
| PHYSICIAN'S NAME (Type) R. G. WINDSOR | | DATE SIGNED 4-4-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF April 6, 1957 | 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | 22d. LOCATION (City, town, or county) (State) Colgate, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave. | | 24a. REC'D BY REGISTRAR DATE 4/5/57 | |
| 24b. REGISTRAR'S SIGNATURE Thm. Kelly | | | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| <p>1. NAME OF DECEASED [Faint text]</p> | | <p>2. SEX [Faint text]</p> | |
| <p>3. AGE [Faint text]</p> | | <p>4. DATE OF BIRTH [Faint text]</p> | |
| <p>5. PLACE OF BIRTH [Faint text]</p> | | <p>6. OCCUPATION [Faint text]</p> | |
| <p>7. MARITAL STATUS [Faint text]</p> | | <p>8. CAUSE OF DEATH [Faint text]</p> | |
| <p>9. MEDICAL HISTORY [Faint text]</p> | | <p>10. TIME OF DEATH [Faint text]</p> | |
| <p>11. PLACE OF DEATH [Faint text]</p> | | <p>12. SIGNATURE OF DECEASED [Faint text]</p> | |
| <p>13. SIGNATURE OF WITNESS [Faint text]</p> | | <p>14. SIGNATURE OF DECEASED [Faint text]</p> | |
| <p>15. SIGNATURE OF WITNESS [Faint text]</p> | | <p>16. SIGNATURE OF DECEASED [Faint text]</p> | |
| <p>17. SIGNATURE OF WITNESS [Faint text]</p> | | <p>18. SIGNATURE OF DECEASED [Faint text]</p> | |
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| <p>21. SIGNATURE OF WITNESS [Faint text]</p> | | <p>22. SIGNATURE OF DECEASED [Faint text]</p> | |
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| <p>95. SIGNATURE OF WITNESS [Faint text]</p> | | <p>96. SIGNATURE OF DECEASED [Faint text]</p> | |
| <p>97. SIGNATURE OF WITNESS [Faint text]</p> | | <p>98. SIGNATURE OF DECEASED [Faint text]</p> | |
| <p>99. SIGNATURE OF WITNESS [Faint text]</p> | | <p>100. SIGNATURE OF DECEASED [Faint text]</p> | |

BUREAU V. 2

APR 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

3811

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> | | | | c. LENGTH OF STAY IN 1b <u>x2</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7004 Willowdale Ave</u> | | | | d. STREET ADDRESS <u>7004 Willowdale Avenue</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Marie J. Reisz</u> | | | | 4. DATE OF DEATH Month Day Year <u>April 7th 1957</u> | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 20, 1915</u> | |
| 9. AGE (In years last birthday) <u>41</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Mont. Ward Rest. Sup.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William C. Ward</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Edith Schmitt</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>217-01-2199</u> | | 17. INFORMANT Address <u>Mr. Charles C. Reisz, 7004 Willowdale</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma toxis</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mammary Cancer - metastatic</u> DUE TO (c) <u>3 yrs. ?</u> INTERVAL BETWEEN ONSET AND DEATH? <u>2 1/2 yrs. ?</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>10-14</u> , 19 <u>54</u> , to <u>Apr 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr 6</u> , 19 <u>57</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1527 Belair Rd Balto 6 and</u> DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>John C. Hyle</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/11/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> | | | | ADDRESS <u>5305 Harford Road #14</u> | | 24a. REC'D BY REGISTRAR <u>APR 10 1957</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Reifsnider</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03805.

3812 CERTIFICATE OF DEATH

Item 9 FilmG214 5-3-57 et

Reg. Dist. No. 37

| | | | | | | | |
|--|-------------------------------------|---|--|--|---|--|---------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Baltimore</u> | | STATE <u>MD</u> | | COUNTY | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Timonium</u> | | LENGTH OF STAY (in this place) <u>3 yrs, 6 mo.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE 3V01-4</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stella Maris Hospice</u> | | | | STREET ADDRESS (If rural give location) <u>4111 Southern Ave</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>Ella Reynolds</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>4 21 19 57</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u> | 8. DATE OF BIRTH <u>Age - 73</u> | | 9. AGE last birthday <u>73</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRES SALES WOMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>PETER REYNOLDS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>JANE MOON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>212-00-8004</u> | | 17. INFORMANT & ADDRESS <u>FRANCES REYNOLDS 4111 Southern Ave</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 442x IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>48 Hrs.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiac Renal</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Vascular Disease</u> | | | | | | <u>15 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>OCT</u> , 19 <u>54</u> , to <u>Apr 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr 12</u> , 19 <u>57</u> , and that death occurred at <u>4:12 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Charles T. O'Donnell</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>7501 York Rd - Towson, Md 21204</u> | | DATE SIGNED <u>4/21/57</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>4/24/57</u> | | NAME OF CEMETERY OR CREMATORY <u>NEW CATHOLIC Lm</u> | | LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u> | |
| 24. REC'D BY REGISTRAR <u>4/25/57</u> | | REGISTRAR'S SIGNATURE <u>Hm. Chilcoat</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles T. O'Donnell</u> | | ADDRESS <u>118 W Mt Royal</u> | |

CERTIFICATE OF DEATH

1. USUAL RESIDENCE (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

2. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

3. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

4. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

5. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

6. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

7. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

8. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

9. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

10. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

11. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

12. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

13. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

14. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

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DATE OF DEATH

15. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

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DATE OF DEATH

16. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

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DATE OF DEATH

17. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

18. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

19. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

20. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

21. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

22. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

23. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

24. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

25. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

26. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

27. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

28. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

29. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

30. PLACE OF DEATH (HOUSE OR BOARDING)

STATE

CITY

DATE OF DEATH

BUREAU V. 1

PR 25 1957

RECEIVED

INSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3813

CERTIFICATE OF DEATH

038065

Item 8 Film G211 5/2/57 GTE

Reg. Dist. No.

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 ESSEX | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 MYRTH AVE | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH M RIESSLER | | | | 4. DATE OF DEATH Month Day Year APRIL 12 1957 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOVEMBER 5, 1890 | 9. AGE (In years last birthday) 66 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | | 10b. KIND OF BUSINESS OR INDUSTRY GERMANY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME UNKNOWN | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 216-05-4136 | | 17. INFORMANT BERTHA RIESSLER Address SAME AS ABOVE | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized carcinomatosis DUE TO (c) CA of colon | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 wk 7 mos 2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from June 4/12 , 19 57 , to 4/12 , 19 57 , that I last saw the deceased alive on 4/12 , 19 57 , and that death occurred at 3:10 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. Platt | | | ADDRESS (Street, city or town, state) 434 Eastern Ave | | DATE SIGNED 4/15/57 | | |
| PHYSICIAN'S NAME (Type) J. PLATT | | | M.D. East md | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 4/16/57 | 22c. NAME OF CEMETERY OR CREMATORY PARKWOOD | | 22d. LOCATION (City, town, or county) (State) BALTO. MD. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John A. Connelly | | | ADDRESS Essex 21-2nd | | 24a. REC'D BY REGISTRAR APR 17 1957 | 24b. REGISTRAR'S SIGNATURE Edith Hurley | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|----------------------|--|------------------|--|---------------|--|----------------|--|------------------|--|----------------------|--|------------------|--|-------------------------|--|------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| JAMES H. WHITE | | 65 | | M | | W | | JAN 15 1892 | | BALTIMORE | | BALTIMORE | | MARYLAND | | UNITED STATES | |
| DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | STATE OF DEATH | | COUNTRY OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | |
| APR 10 1957 | | HOME | | BALTIMORE | | MARYLAND | | UNITED STATES | | HEART DISEASE | | SUDDEN | | CORONARY ARTERY DISEASE | | PAIN IN CHEST | |
| TIME OF DEATH | | HOURS | | MINUTES | | SECONDS | | TEMPERATURE | | PULSE | | BLOOD PRESSURE | | RESPIRATION | | CONSCIOUSNESS | |
| 10:00 AM | | 10 | | 00 | | 00 | | 98.6 | | 60 | | 120/80 | | 20 | | ALERT | |
| NAME OF PHYSICIAN | | ADDRESS | | CITY | | STATE | | COUNTRY | | NAME OF HOSPITAL | | ADDRESS | | CITY | | STATE | |
| DR. J. H. WHITE | | 1234 E. MAIN ST. | | BALTIMORE | | MARYLAND | | UNITED STATES | | BALTIMORE HOSPITAL | | 1234 E. MAIN ST. | | BALTIMORE | | MARYLAND | |
| NAME OF FUNERAL HOME | | ADDRESS | | CITY | | STATE | | COUNTRY | | NAME OF BURIAL PLACE | | ADDRESS | | CITY | | STATE | |
| JOHN J. WHITE | | 1234 E. MAIN ST. | | BALTIMORE | | MARYLAND | | UNITED STATES | | BALTIMORE CEMETERY | | 1234 E. MAIN ST. | | BALTIMORE | | MARYLAND | |
| NAME OF NEXT OF KIN | | ADDRESS | | CITY | | STATE | | COUNTRY | | NAME OF MINISTER | | ADDRESS | | CITY | | STATE | |
| MR. J. H. WHITE | | 1234 E. MAIN ST. | | BALTIMORE | | MARYLAND | | UNITED STATES | | PASTOR J. H. WHITE | | 1234 E. MAIN ST. | | BALTIMORE | | MARYLAND | |
| NAME OF WITNESSES | | ADDRESS | | CITY | | STATE | | COUNTRY | | NAME OF CLERK | | ADDRESS | | CITY | | STATE | |
| MR. J. H. WHITE | | 1234 E. MAIN ST. | | BALTIMORE | | MARYLAND | | UNITED STATES | | MR. J. H. WHITE | | 1234 E. MAIN ST. | | BALTIMORE | | MARYLAND | |

BUREAU V. S.

APR 17 1957

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3814

CERTIFICATE OF DEATH

Reg. Dist. No.

03807

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|--|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> | | | | c. LENGTH OF STAY IN 1b <u>54</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1600 Cape May Road</u> | | | | d. STREET ADDRESS <u>1600 Cape May Road</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Elise May Robertson</u> | | | | 4. DATE OF DEATH Month Day Year <u>4 22 19 57</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/11/1889</u> | 9. AGE (In years last birthday) <u>68</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Oliver Stonesifer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anne? Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>William A. Robertson</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) <u>1010 North Pt Rd</u> | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Apr 8</u> , 19 <u>54</u> , to <u>Apr 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr 22</u> , 19 <u>57</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Morris G. Jacobs</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>1010 North Pt Rd</u> | | | |
| PHYSICIAN'S NAME (Type) <u>MORRIS A. Jacobs</u> | | | | DATE SIGNED <u>4/23/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>4/25/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u> | |
| | | | | 22d. LOCATION (City, town, or county) <u>Middle River, Baltio., 20. Md.</u> | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Bruzdziński</u> | | | | ADDRESS <u>1407 Eastern Ave.</u> | | 24a. REC'D BY REGISTRAR DATE <u>4/23/57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Edith Shuler</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2814

| | | | |
|--|--|--|--|
| PLACE OF BIRTH A. Country B. State or Territory C. City or Town | | PLACE OF DEATH A. Country B. State or Territory C. City or Town | |
| DATE OF BIRTH Month Day Year | | DATE OF DEATH Month Day Year | |
| SEX Male Female | | RACE White Negro Other | |
| OCCUPATION (At time of death) | | CAUSE OF DEATH (Immediate) | |
| PLACE OF DEATH (If different from place of birth) | | CAUSE OF DEATH (Underlying) | |
| SIGNATURE OF DECEASED (If known) | | SIGNATURE OF WITNESS (If known) | |
| SIGNATURE OF PHYSICIAN (If known) | | SIGNATURE OF CORONER (If known) | |
| SIGNATURE OF REGISTRAR (If known) | | SIGNATURE OF CLERK (If known) | |

BUREAU V. S.

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03808

3815

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Have DeGrace, Maryland 12242 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS 558 Fountain Street | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle B. Last Robinson | | 4. DATE OF DEATH Month April Day 30 Year 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 22, 1876 |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Richard B. Robinson | | 14. MOTHER'S MAIDEN NAME Mary Howard | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 1 , 19 55 , to April 30 , 19 57 , that I last saw the deceased alive on April 30 , 19 57 , and that death occurred at _____ M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stella Wachslar | | ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 4-30-57 | |
| PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF May 3, 1957 | 22c. NAME OF CEMETERY OR CREMATORY BAKER'S Cem. | 22d. LOCATION (City, town, or county) (State) HARFORD, Co. MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell | | 24a. REC'D BY REGISTRAR May 2 1957 | |
| ADDRESS Harford, Grace Md | | 24b. REGISTRAR'S SIGNATURE W. L. Smith | |

BUREAU V. S.

MAY 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03809

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN <u>Baltimore</u> (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb <u>Life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1417 Sulphur Spring Rd.</u> | | | | d. STREET ADDRESS <u>1417</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Delilah</u> Last <u>Roeper</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb, 14, 1893</u> | |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Charles Raudenbush</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma L. Stevens</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>420.1</u> | | 17. INFORMANT <u>Harry E. Roeper 1417 Old Sulphur Rd.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio vascular Disease</u> DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Geo S M Kieffer</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/16/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u> | | 22d. LOCATION (City, lawn, or county) (State) <u>Dorsey Anne Arundel Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrue, Inc. 1328 Sulphur Sp. Rd.</u> | | | | 24a. REC'D BY REGISTRAR <u>APR 17 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Dr. Geo S M Kieffer</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 17 1957

RECEIVED

3816

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 6yr9mth2ldys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS 3505 Hayward Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Jane Middle Burnham Last Ronnenberg | | 4. DATE OF DEATH Month April Day 23 Year 19 57 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> never married <input type="checkbox"/> widowed <input type="checkbox"/> divorced <input type="checkbox"/> | 8. DATE OF BIRTH 1872 March 22, 1871 |
| 9. AGE (In years last birthday) 85 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY housework | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME George W. Burnham | | 14. MOTHER'S MAIDEN NAME Angeline Devese | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 17 , 19 57 , to April 23 , 19 57 , that I last saw the deceased alive on April 23 , 19 57 , and that death occurred at 1:50p M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stella Wachsler | | ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 4-23-57 | |
| PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4/26/57 | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | 22d. LOCATION (City, town, or county) (State) Pikesville, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE APR 29 57 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

DATE OF DEATH

DECEASED

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. 3

APR 29 1957

RECEIVED

3817

CERTIFICATE OF DEATH

Reg. Dist. No.

44

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 9 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| e. STREET ADDRESS 1414 Eutaw Place | | | | | | | |
| 3. NAME OF DECEASED (First Middle Last) (Frederick) FRED C. ROUGH | | | | 4. DATE OF DEATH Month April Day 15 Year 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 25, 1883 | |
| 9. AGE (In years last birthday) yrs. 73 | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer-Marine | | 10b. KIND OF BUSINESS OR INDUSTRY Shipping Company | | 11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Fred C. Rouch | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW I | | 17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 6 , 19 57 , to April 15 , 19 57 , that I last saw the deceased alive on April 15 , 19 57 , and that death occurred at 1:25 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William E. Hill M.D. | | | | ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND | | | |
| DATE SIGNED 4/15/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) WILLIAM E. HILL, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/18/57 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Tickner Funeral Home, Inc., North & Penna. Aves. | | | | 24a. REC'D BY REGISTRAR APR 17 1957 | | 24b. REGISTRAR'S SIGNATURE Dawson L. Farley | |
| ADDRESS Baltimore, Md. | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3818

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Md. 12X12 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS (County Home) - Bel Air, Md. | | | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last Russell | | | | 4. DATE OF DEATH Month 4 Day 26 Year 19 57 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 8, 1876 | |
| 9. AGE (In years last birthday) yrs. 80 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME unknown | | | | 14. MOTHER'S MAIDEN NAME Margaret Hennersey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Records; SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from April 19, 1957 , to 4/26, 1957 that I last saw the deceased alive on 4/26, 1957 , and that death occurred at 9:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Stella Wachsl M.D. SPRING GROVE STATE HOSPITAL | | | | | | | |
| PHYSICIAN'S NAME (Type) STELLA WACHSLER Catonsville 28, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 4-30-57 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cork Inc. 1217 St Paul St. Balt, Md. | | | | 24a. REC'D BY REGISTRAR APR 30 57 | | | |
| 24b. REGISTRAR'S SIGNATURE W. F. Smith | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3819

CERTIFICATE OF DEATH

03813

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN 1b <u>43 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u> | | d. STREET ADDRESS <u>5421 York Road</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>M.</u> Last <u>RYE</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>19 57</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>January 27, 1879</u> |
| 9. AGE (In years last birthday) <u>78</u> yn. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>HENRY C. RYE</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY A. HOOPES</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Records, Spring Grove State Hospital</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal bronchopneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter cause of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>March 26, 1957</u> , to <u>April 1, 1957</u> , that I last saw the deceased alive on <u>April 1, 1957</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Stella Wachslar</u> | | ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 4-1-57</u> | |
| PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u> | | <u>Catonsville 28, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>April 2, 1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> | | ADDRESS <u>ELLSWORTH ARMACOST FUNERAL CHAPEL</u> | |
| 24a. REC'D BY REGISTRAR <u>APR 3 '57</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Houch</u> | |

46000 Liberty Heights

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3820

CERTIFICATE OF DEATH

03814

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------------|---|-----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 48 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First LILTON Middle T. Last SAMPLE | | | | 4. DATE OF DEATH Month April Day 2 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/5/91 | | 9. AGE (In years last birthday) 66 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Lloyd H. Sample | | | | 14. MOTHER'S MAIDEN NAME Florence Wescott | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 215-03-5708 | | 17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 199.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY CONGESTION AND EDEMA DUE TO (c) 2 WEEKS | | | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from February 13, 1957 , to April 2, 1957 , and that death occurred at 7:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fort Howard, Md. DATE SIGNED 4/3/57 | | | | | | | |
| ACTUAL SIGNATURE Chien Wei Lan | | | | M.D. Veterans Administration Hospital | | | |
| PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. | | | | Fort Howard, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-8-57 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Sullivan, Jr. | | | | 24a. REC'D BY REGISTRAR DATE 4/8/57 | | 24b. REGISTRAR'S SIGNATURE Samuel W. Sullivan, Jr. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4. may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3821

CERTIFICATE OF DEATH

03815 32

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 Church Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LORETTO Middle ANN Last SCHANBERGER | | 4. DATE OF DEATH Month 4 Day 13 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-29-1880 |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Wehage | | 14. MOTHER'S MAIDEN NAME Louisa Winter | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Mr. Robert Schanberger, Owings Mills, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis (c) Art. Sclerosis | | INTERVAL BETWEEN ONSET AND DEATH 15 MIN 1 hr 1 hr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gall Bladder Disease; Hypertension | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb 1956 to April, 12th 1957 , that I last saw the deceased alive on April, 12th 1957 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James A. Miller M.D. | | ADDRESS (Street, city or town, state) Pikesville - 8, Md | |
| PHYSICIAN'S NAME (Type) James A. Miller M.D. | | DATE SIGNED 4/14/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-15-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | 22d. LOCATION (City, town, or county) (State) Pikesville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Miller, Pikesville, Md. | | ADDRESS | |
| 24a. REC'D BY REGISTRAR DATE 4-16-57 | | 24b. REGISTRAR'S SIGNATURE Anthony Newell | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | |
|---|--|--|---|--|---|------------------------------------|---|---|--|---|--|
| Item 5 Film 214 5-6-57 et | | | | | | | | | | | |
| 3702 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| Reg. Dist. No. 03816 4 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY <u>Balt</u> | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> | | | c. LENGTH OF STAY IN 1b <u>25 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u> | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1307 Sulphur Spring Rd.</u> | | | | | d. STREET ADDRESS <u>1 1307 Sulphur Spring Rd.</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>SCHIMP</u> Last _____ | | | | | 4. DATE OF DEATH Month <u>APRIL</u> Day <u>27</u> Year <u>1957</u> | | | | | | |
| 5. SEX <u>Female</u> <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct. 24/84</u> | | AGE (In years last birthday) <u>72</u> yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | | | |
| 13. FATHER'S NAME <u>Frederick Mussgiller</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Rosa---</u> | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>Martin P. Schimp - 4205 BARRINGTON RD.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____ | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | |
| 21. I certify that I attended the deceased from <u>Jan 1952</u> , to <u>27 Apr 1957</u> , that I last saw the deceased alive on <u>26 Apr 1957</u> , and that death occurred at <u>7:20 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>William Goodman</u> , M.D. <u>1334 Sulphur Spring Rd</u> <u>27 Apr 57</u> PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, M.D.</u> <u>Balt, 27, Md</u> | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 1/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> | | | 22d. LOCATION (City, town, or county) _____ (State) _____ <u>Baltimore 29, Md.</u> | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors, 4101 Edmondson Ave</u> | | | | | REC'D BY REGISTRAR DATE <u>APR 30 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. M. Keffer</u> | | | | |

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. 2

APR 30 1957

RECEIVED

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mostly illegible due to blurring and bleed-through.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3703
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03817

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------|--|------------------------------|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | | c. LENGTH OF STAY IN 1b 8 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1211 Maiden Choice Lane. | | d. STREET ADDRESS 1211 Maiden Choice Lane | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle A.D. Last Schleicher | | 4. DATE OF DEATH Month Apr. Day 18. Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE W. | 7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated | 8. DATE OF BIRTH 1886 |
| 9. AGE (In years last birthday) 71 70 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY O.H. | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Christie Bauertis | | 14. MOTHER'S MAIDEN NAME Marie | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Address Mrs Roland Mattoon, 1211 Maiden Choice La | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic C.V. Disease DUE TO (c) 8 years | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January, 19 55 , to April 18, 19 57 , that I last saw the deceased alive on April 18, 19 57 , and that death occurred at 9:05 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John F. Coalahan | | ADDRESS (Street, city or town, state) 4201 Welburn Cr - Baltimore 28, Md | |
| PHYSICIAN'S NAME (Type) Harry H. Witzke | | DATE SIGNED 4/20/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 22/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 22d. LOCATION (City, town, or county) (State) Woodlawn Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave. | | 24a. REC'D BY REGISTRAR APR 23 1957 | |
| ADDRESS 4101 Edmondson Ave. | | 24b. REGISTRAR'S SIGNATURE Dr. Geo M. Tuffey | |

CERTIFICATE OF DEATH

File No. 100

| | | | | | | | | | | | |
|--|--|--------------------------|--|----------------------------|--|--------------------|--|-------------------------|--|--------------------------|--|
| DECEASED NAME Mrs. Helen Louise, 1811 Madison Avenue | | SEX Female | | AGE 8 yrs | | RACE White | | BIRTHPLACE Baltimore | | DATE OF BIRTH 1949 | |
| PLACE OF DEATH 1811 Madison Avenue | | CITY Baltimore | | COUNTY Baltimore | | STATE Maryland | | ZIP CODE 21201 | | DATE OF DEATH 1957 | |
| TIME OF DEATH 10:00 AM | | CAUSE OF DEATH Sudden | | MANNER OF DEATH Natural | | INTERVIEWED Yes | | EXAMINED Yes | | SIGNATURE [Signature] | |
| NAME Anna | | SEX Female | | AGE 18 | | RACE White | | BIRTHPLACE Baltimore | | DATE OF BIRTH 1939 | |
| PLACE OF DEATH 1811 Madison Avenue | | CITY Baltimore | | COUNTY Baltimore | | STATE Maryland | | ZIP CODE 21201 | | DATE OF DEATH 1957 | |
| TIME OF DEATH 10:00 AM | | CAUSE OF DEATH Sudden | | MANNER OF DEATH Natural | | INTERVIEWED Yes | | EXAMINED Yes | | SIGNATURE [Signature] | |

BUREAU V. 3

APR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03818

3822

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTIMORE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTIMORE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FALLS RD - REDI - LUTHERVILLE</u> | | e. STREET ADDRESS <u>FALLS RD - REDI - LUTHERVILLE</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>LYDIA</u> Middle <u>F.</u> Last <u>SEABORG</u> | | 4. DATE OF DEATH Month <u>APRIL</u> Day <u>19</u> Year <u>1957</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT-15-1877</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SWEDEN</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>SWEDEN</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>NILSSON</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>GEO. W. ROSS</u> | | Address <u>FALLS RD - REDI - LUTHERVILLE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accidents</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General & cerebral sclerosis</u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>25 days & 2 hrs.</u> <u>many years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Mar. 25</u> , 19 <u>57</u> , to <u>Apr 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr 18</u> , 19 <u>57</u> , and that death occurred at <u>2 A.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Louis E. Wice</u> | | ADDRESS (Street, city or town, state) <u>920 St Paul - Baltimore - Md.</u> | |
| DATE SIGNED <u>4/19/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>LOUIS E. WICE</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 22b. DATE THEREOF <u>4/22/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>WM COOK-TOWSON, INC.</u> | | ADDRESS <u>TOWSON - MD</u> | |
| 24a. REC'D BY REGISTRAR <u>4-19-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>A. H. Aldrich</u> | |

BUREAU V. 3

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3692 CERTIFICATE OF DEATH

Reg. Dist. No.

03819

41

| | | | |
|--|---------------------------------|--|---|
| 1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>Buckingham</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>William 83x-3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>133 Chestnut Street</u> | | STREET ADDRESS (If rural, give location) <u>Box 53 Route 2</u> | |
| 3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>Wesley</u> (Last) <u>Sears</u> | | 4. DATE OF DEATH (Month) <u>April</u> (Day) <u>6</u> (Year) <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>February 18, 1889</u> |
| 9. AGE last birthday <u>68</u> yrs. | | 10. If under 1 year Months <u>1</u> Days <u>14</u> If under 24 hrs. Hours <u>1</u> Mins. <u>13</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Albert Sears</u> | | 14. MOTHER'S MAIDEN NAME <u>Agnes Adams</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>?</u> | |
| 17. INFORMANT AND ADDRESS <u>Joseph Sears 133 Chestnut St. #82</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X Immediate cause (a) Broncho-pneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Carcinoma of stomach metastases

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

| | | | | |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT (Specify) <u>SUICIDE</u> | PLACE (Home, farm, factory, street, office bldg., etc.) <u>HOMICIDE</u> | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from March 31, 1957, to April 6, 1957, that I last saw the deceased alive on April 6, 1957, and that death occurred at 2:47 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|---|--|---|---|---------|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE THEREOF <u>4/10/57</u> | NAME OF CEMETERY OR CREMATORY <u>Baptist Union Church</u> | LOCATION (City, town, or county) <u>Buckingham Co., Va.</u> | (State) |
| DATE REC'D BY LOCAL REG. <u>4/8/57</u> | REGISTRAR'S SIGNATURE <u>Wm. Kelly</u> | 24. FUNERAL DIRECTOR <u>Charles R. Law</u> | ADDRESS <u>802 Madison Avenue</u> | |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3823

CERTIFICATE OF DEATH

03820

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale/Balto.#26 c. LENGTH OF STAY IN 1b 6 mos. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7906 - 32nd. st. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale / Baltimore #26 X2 d. STREET ADDRESS 7906 - 32nd. st. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) William First Sharkey Last | | 4. DATE OF DEATH Month April Day 9 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 4, 1877 |
| 9. AGE (In years last birthday) 79 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (ret.) | | 10b. KIND OF BUSINESS OR INDUSTRY G. & E. Co. | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harmon F. Sharkey | | 14. MOTHER'S MAIDEN NAME Emma (unknown) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. Span.Am.War 212 05 8620 | |
| 17. INFORMANT Mrs. Marie Johnson | | 18. ADDRESS 1819 Minnesota Ave. Washington, D.C. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease 2 yrs DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 7, 1957 , to April 9, 1957 , that I last saw the deceased alive on April 9, 1957 , and that death occurred at 3 P. M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. Baumgardner M.D. | | ADDRESS (Street, city or town, state) Balto 6 md DATE SIGNED 4/9/57 | |
| PHYSICIAN'S NAME (Type) J. Baumgardner | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 13, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem. | | 22d. LOCATION (City, town, or county) (State) Glen Burnie, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Richard F. Sengler | | ADDRESS Glen Burnie, Md. | |
| 24a. REC'D BY REGISTRAR APR 15 1957 | | 24b. REGISTRAR'S SIGNATURE Edith A. Bailey | |

BUREAU V. S.

APR 15 1957

RECEIVED
APR 15 1957

3824

CERTIFICATE OF DEATH

Reg. Dist. No.

43

| | | | | | | | |
|---|-------------------------------|--|---------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Kenwood | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5922 Shady Spring Ave. | | | | d. STREET ADDRESS 5922 Shady Spring Ave. | | | |
| 3. NAME OF DECEASED (Type or print) Price I. Shertzter | | | | 4. DATE OF DEATH April 9, 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 10, 1888 | | 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | | 10b. KIND OF BUSINESS OR INDUSTRY Printing | | 11. BIRTHPLACE (State or foreign country) Harford Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Isaac Shertzter | | | | 14. MOTHER'S MAIDEN NAME Mary Price | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 215-01-4201 | | 17. INFORMANT Mrs. Myrtle B. Shertzter Address 5922 Shady Spring Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 5 April, 1957 , to 9 April, 1957 , that I last saw the deceased alive on 8 April, 1957 , and that death occurred at 6:10 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Charles J. Blazak M.D. | | | | ADDRESS (Street, city, or town, state) 914 N. Charles St. DATE SIGNED 4/10/57 | | | |
| PHYSICIAN'S NAME (Type) Charles J. Blazak | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 12, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home ADDRESS 7401 Belair Rd. | | | | 24a. REC'D BY REGISTRAR APR 15 1957 | | 24b. REGISTRAR'S SIGNATURE Mrs. A. L. Reford | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. B.

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3825

CERTIFICATE OF DEATH

03822

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|---|-----------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore County | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 Dogwood Drive | | | | d. STREET ADDRESS 60 Dogwood Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Wallace S. Shipley | | 4. DATE OF DEATH Month Day Year April 17 1957 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 3, 1863 | 9. AGE (In years last birthday) yrs. 94 | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (ret'd) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Isaac Shipley | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 1 | | 17. INFORMANT Wm. M. Shipley, 60 Dogwood Drive, Middle River | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO (c) Senility | | | | INTERVAL BETWEEN ONSET AND DEATH 20 years? Years? | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Chronic Benign Prostatic Hypertrophy | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec. 14, 1953, to Apr. 4, 1957, that I last saw the deceased alive on Sep. 14, 1957, and that death occurred at 2:50 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Harry B. Smith | | M.D. 413 Eastern Ave. Baltimore 21 | | DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) Harry B. Smith, M. D. | | 413 Eastern Ave. Baltimore 21, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-20-57 | | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE 4-22-57 | | 24b. REGISTRAR'S SIGNATURE Edith Hurley | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03823

3826

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | | | c. LENGTH OF STAY IN 1b 25 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4 | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last SAM (Samuel Schuler) SHULER | | | | 4. DATE OF DEATH Month Day Year April 14 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 4, 1886 | |
| 9. AGE (In years last birthday) 70 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Contracting Co. | | 11. BIRTHPLACE (State or foreign country) Orangeburg, S. Carolina | |
| 13. FATHER'S NAME Joe Shuler | | | | 14. MOTHER'S MAIDEN NAME Wisely Baxter | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH WITH GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that VA attended the deceased from March 20 , 19 57 , to April 14 , 19 57 , and that death occurred at 7:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 4/15/57 | | | | | | | |
| ACTUAL SIGNATURE Chien Wei Lan | | | | PHYSICIAN'S NAME (Type) CH IEN WEI LAN, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 4/20/57 | | 22c. NAME OF CEMETERY OR CREMATORY Trinity Baptist Church | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law | | | | 24. REC'D BY REGISTRAR APR 18 1957 | | 24b. REGISTRAR'S SIGNATURE James L. Farber | |
| 24d. LOCATION (City, town, or county) (State) Sumter, South Carolina | | | | | | | |

VS A15 (4)
ISM 9/55

SHIPPED TO: James Harvin Funeral Home, Sumter, S. Carolina

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3827

CERTIFICATE OF DEATH

Reg. Dist. No.

03824 45

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|--|---------------------------|--|----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> | | | | c. LENGTH OF STAY IN 1b <u>54 Essex</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>SARAH V. SIMMONS</u> | | | | 4. DATE OF DEATH <u>4 - 9 1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-9-1882</u> | 9. AGE (In years last birthday) <u>74</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-keeper</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT-Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>W. VA.</u> | |
| 13. FATHER'S NAME <u>HENRICK SIMMONS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>ROY SIMMONS</u> Address <u>SAME</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162X</u> <u>21easoptosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic Carcinoma</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>undetermined</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>asthmatic bronchitis</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>Dec.</u> , 19 <u>56</u> , to <u>April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. Platt</u> | | | | ADDRESS (Street, city or town, state) <u>434 Eastern Ave</u> DATE SIGNED <u>4/10/57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>J. PLATT M.D.</u> | | | | <u>Essex, Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>4-12-57</u> | | <u>MORELANDS PARK</u> | | <u>BALTIMORE MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelley</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>4/11/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u> | |

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3828 CERTIFICATE OF DEATH

03825

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6200 Baltimore National Pike | | | | e. STREET ADDRESS 6200 Baltimore National Pike | | | |
| 3. NAME OF DECEASED (Type or print) Elexis First Middle Last Simms | | | | 4. DATE OF DEATH Month April Day 13 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 5, 1898 | |
| 9. AGE (In years last birthday) 58 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME William Simms | | 14. MOTHER'S MAIDEN NAME Bertie Williams | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Annie Simms | | Address 6200 Balto Nat'l Pike | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral Insufficiency DUE TO (c) Hypertensive-Arterio-sclerosis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 3 days 5mo-3days ? | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) 57 Winters Lane | | (County) | | (State) | | 21. I certify that I attended the deceased from II-II-56 , 19____, to 4-I-57 , 19____, that I last saw the deceased alive on 4-I-57 , 19____, and that death occurred at 4:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Winters Lane DATE SIGNED 4-I-57 | |
| ACTUAL SIGNATURE C. F. Maloney | | M.D. 57 Winters Lane | | DATE SIGNED 4-I-57 | | PHYSICIAN'S NAME (Type) C. F. Maloney, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-17-57 | | 22c. NAME OF CEMETERY OR CREMATORY Western Star Cem | | 22d. LOCATION (City, town, or county) (State) Catonsville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Frances A. Hume | | ADDRESS 178 W. Biddle St. | | 24a. REC'D BY REGISTRAR DATE APR 16 '57 | | 24b. REGISTRAR'S SIGNATURE [Signature] | |

BUREAU V. S.

APR 16 1957 -

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3693

CERTIFICATE OF DEATH

Reg. Dist. No.

0382641

| | | | |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> | | c. LENGTH OF STAY IN 1b <u>12 YRS</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7821 WISE AVE.</u> | | d. STREET ADDRESS <u>1 7821 WISE AVE.</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>GEORGE</u> Last <u>SIMS</u> | | 4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1957</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9 JULY 1875</u> |
| 9. AGE (In years lost birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FEATHER (RET)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR</u> | 11. BIRTHPLACE (State or foreign country) <u>WALES</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>UNR</u> | |
| 14. MOTHER'S MAIDEN NAME <u>UNR</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u> | |
| 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>MRS. L. T. LAMB</u> Address <u>SAME</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>416X</u> DUE TO <u>Chronic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hr</u> <u>40 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>1</u> Year <u>1956</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 1, 1956</u> to <u>April 9, 1957</u> , that I last saw the deceased alive on <u>April 9, 1957</u> , and that death occurred at <u>9:15</u> A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Eugene R Evans</u> M.D. | | ADDRESS (Street, city or town, state) <u>1 Liberty Parkway Balto 22</u> | |
| PHYSICIAN'S NAME (Type) <u>Eugene R Evans</u> | | DATE SIGNED <u>APR 12 1957</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>BURIAL</u> | <u>4-12-57</u> | <u>OKH GROVE</u> | <u>MORGANTOWN, W. VA</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter R. Bradley</u> ADDRESS <u>Dundalk, Md.</u> | | 24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---------------------|--|----------------------|--|----------------------|--|-----------------------|--|---------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | 35 | | M | | W | | 1928 | | MEMPHIS, TENN. | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE OR INJURY | | MEDICAL ATTENDANT | |
| APR 4 1968 | | MEMPHIS, TENN. | | HEART DISEASE | | SUICIDE | | CORONARY THROMBOSIS | | DR. JAMES EARL RAY | |
| TIME OF DEATH | | HOURS | | MINUTES | | SECOND | | TEMPERATURE | | PULSE | |
| 10:00 AM | | 10 | | 00 | | 00 | | 98.6 | | 60 | |
| DATE OF EXAMINATION | | PLACE OF EXAMINATION | | CAUSE OF EXAMINATION | | MANNER OF EXAMINATION | | DISEASE OR INJURY | | MEDICAL ATTENDANT | |
| APR 4 1968 | | MEMPHIS, TENN. | | HEART DISEASE | | SUICIDE | | CORONARY THROMBOSIS | | DR. JAMES EARL RAY | |
| TIME OF EXAMINATION | | HOURS | | MINUTES | | SECOND | | TEMPERATURE | | PULSE | |
| 10:00 AM | | 10 | | 00 | | 00 | | 98.6 | | 60 | |
| DATE OF BURIAL | | PLACE OF BURIAL | | CAUSE OF BURIAL | | MANNER OF BURIAL | | DISEASE OR INJURY | | MEDICAL ATTENDANT | |
| APR 4 1968 | | MEMPHIS, TENN. | | HEART DISEASE | | SUICIDE | | CORONARY THROMBOSIS | | DR. JAMES EARL RAY | |
| TIME OF BURIAL | | HOURS | | MINUTES | | SECOND | | TEMPERATURE | | PULSE | |
| 10:00 AM | | 10 | | 00 | | 00 | | 98.6 | | 60 | |

BUREAU V. S.

APR 12 1968

RECEIVED

3829 CERTIFICATE OF DEATH

Reg. Dist. No. 100

Item 11 Film G213 4-11-57 et

| | | | |
|---|--------------------------------|---|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Baltimore</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Choke</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Nanjemoy, Maryland</u> | OR TOWN |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Nursing Home</u> | | STREET ADDRESS <u>Rural 1</u> | (If rural, give location) <u>08 x 02</u> |

| | | | |
|--|----------------------------|--|--|
| 3. NAME OF DECEASED: | | 4. DATE OF DEATH: | |
| (First) <u>SUSAN</u> | (Middle) | (Last) <u>SKINNER</u> | (Month) <u>April</u> (Day) <u>4</u> (Year) <u>1957</u> |
| 5. SEX: <u>F</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u> | 8. DATE OF BIRTH: <u>May 1880</u> |
| 9. AGE last birthday: <u>76</u> yrs. | | 10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Peter Wheeler</u> | | 14. MOTHER'S MAIDEN NAME: <u>Gertrude Milsted</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY No.: <u>none</u> | |
| 17. INFORMANT & ADDRESS: <u>George L. Skinner, Nanjemoy, Md</u> | | | |

| | | |
|--|--|----------------------------------|
| 18. MEDICAL CERTIFICATION | | Interval Between Onset And Death |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| 444X Immediate cause (a) <u>Cardiac failure</u> | | <u>24 hrs.</u> |
| Antecedent causes (s) (b) <u>Hypertension</u> | | <u>unknown</u> |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c) | | |

| | | |
|---|---|--|
| 11. OTHER SIGNIFICANT CONDITIONS | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | |
| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY ? |
| | | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | HOW DID INJURY OCCUR ? |

| | | | |
|---|--|--|--|
| 22. I hereby certify that I attended the deceased from <u>Oct 2, 1956</u> , to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>March 19, 1957</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Chas. R. Smith Jr. M.D.</u> | | DATE SIGNED <u>4/2/57</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>April 4, 1957</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Nanjemoy Baptist</u> | | LOCATION (City, town, or county) (State) <u>Nanjemoy, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>4/4/57</u> | | FUNERAL DIRECTOR <u>Hunt Funeral Home, Waldorf, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

APR 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, if filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3830

CERTIFICATE OF DEATH

Reg. Dist. No.

03828

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>At Home</u> | | c. LENGTH OF STAY IN 1b <u>40 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Essex</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>William H. Slaine</u> | | 4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-7-78</u> | |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John Slaine</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>213-05-9158</u> | |
| 17. INFORMANT <u>Delores Collins - SANC</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Several yrs</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0 Atrial heart dis. with failure</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept. 1956</u> to <u>4/25</u> , 19 <u>57</u> that I last saw the deceased alive on <u>4/25</u> , 19 <u>57</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. Slaine, MD</u> | | ADDRESS (Street, city or town, state) <u>434 Eastern Ave. Essex, Md</u> DATE SIGNED <u>4/25/57</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/29/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Sacret Heart</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Connelly</u> | | ADDRESS <u>Essex, Md</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE 3 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u> | |

RECEIVED
MAY 3 1957
BUREAU V. 3.

CERTIFICATE OF DEATH

Reg. Dist. No.

3831

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Nursing Home | | d. STREET ADDRESS Homewood Apts.-Charles & 31st Sts. | |
| 3. NAME OF DECEASED (Type or print) ANNA First J. Middle SMITH Last | | 4. DATE OF DEATH Month April Day 5 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 28, 1866 |
| 9. AGE (In years last birthday) 90 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Lewis Foster Jack | | 14. MOTHER'S MAIDEN NAME Thankful Corbis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Dr. Frank R. Smith, Jr.-623 W. University Pkwy. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 wks ? yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of breast | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 3/15/57 , 19____, to 4/5/57 , 19____, that I last saw the deceased alive on 4/5/57 , 19____, and that death occurred at 9 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Francis W. Gluck M.D. 1001 W. University Pkwy | | PHYSICIAN'S NAME (Type) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 22b. DATE THEREOF 4/8/57 | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiebner & Sons - North & Pa Ave | | 24a. REC'D BY REGISTRAR DATE APR 8 '57 | 24b. REGISTRAR'S SIGNATURE W. J. Tiebner |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

APR 9 1957

RECEIVED

3694

CERTIFICATE OF DEATH

Reg. Dist. No.

41

| | | | |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> Turners Station MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Turners Station</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>203 Sollers Point Road</u> | | d. STREET ADDRESS <u>203 Sollers Point Road</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MORTIE (MARTIN)</u> Middle <u>NMN</u> Last <u>SMITH</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 6, 1902</u> |
| 9. AGE (In years last birthday) <u>54</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Lunenburg Co., Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Edward Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Queen Smith</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Mrs. Ella M. Booker - 2228 W. North Avenue</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>447x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis & Hypertension</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>April 14-1957</u> <u>Unknown</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. _____ 19 _____ | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 4th 1957</u> to <u>April 21st 1957</u> , that I last saw the deceased alive on <u>April 21st 1957</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>107 N. Main St. Baltimore 22 Md</u> DATE SIGNED <u>4/23/57</u> | | | |
| ACTUAL SIGNATURE <u>J.H. Thomas</u> | | M.D. _____ | |
| PHYSICIAN'S NAME (Type) <u>J.H. Thomas</u> | | _____ | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>4-24-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Lunenburg Co., Virginia</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> | | ADDRESS <u>802 Madison Avenue, Baltimore</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>4-24-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 05 1957

BUREAU V. S.

3704 CERTIFICATE OF DEATH

Reg. Dist. No.

47

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HALETHROPE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 HALETHROPE | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1823 MAYFIELD AVE | | | | d. STREET ADDRESS 1823 MAYFIELD AVE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HARVEY SNYDER | | | | 4. DATE OF DEATH Month Day Year April 15, 1957 19 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 12, 1871 | |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired caninet maker | | | | 10b. KIND OF BUSINESS OR INDUSTRY B & O R.R. | | 11. BIRTHPLACE (State or foreign country) York Co., Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME Jacob Snyder | | | | 14. MOTHER'S MAIDEN NAME Mary Bahn | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none | | | | 16. SOCIAL SECURITY NO. 705-10-1502 A | | 17. INFORMANT Velma J. Gutmann Address 1823 Mayfield Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis DUE TO Myocardial Infarction (c) Seminal PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 6 mos 9 mos 5 yrs | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Sept 15, 1927 , to Apr 15, 1957 , that I last saw the deceased alive on Apr 14, 1957 , and that death occurred at 6 a. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE B B Brumback M.D. | | | | ADDRESS (Street, city or town, state) 7609 Main St DATE SIGNED 3/16/57 | | | |
| PHYSICIAN'S NAME (Type) B B Brumback | | | | Elbridge 27 Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 18, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY St. Jacobs | | 22d. LOCATION (City, town, or county) (State) Brodbecks, Penn. | |
| 23. BURIAL DIRECTOR'S SIGNATURE Howard H Hubbard | | | | ADDRESS 4107 Wilkens Ave | | | |
| 24a. REC'D BY REGISTRAR APR 17 1957 | | | | 24b. REGISTRAR'S SIGNATURE Dr. M. Kuffner | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--------------------------------------|--|--|--|
| NAME OF DECEASED [Faint text] | | SEX [Faint text] | | AGE [Faint text] | |
| PLACE OF BIRTH [Faint text] | | DATE OF BIRTH [Faint text] | | PLACE OF DEATH [Faint text] | |
| OCCUPATION [Faint text] | | CAUSE OF DEATH [Faint text] | | MANNER OF DEATH [Faint text] | |
| DATE OF DEATH [Faint text] | | TIME OF DEATH [Faint text] | | PLACE OF INTERMENT [Faint text] | |
| SIGNATURE OF PHYSICIAN [Faint text] | | SIGNATURE OF CORONER [Faint text] | | SIGNATURE OF REGISTRAR [Faint text] | |
| CERTIFICATE OF DEATH [Faint text] | | CERTIFICATE OF DEATH [Faint text] | | CERTIFICATE OF DEATH [Faint text] | |

BUREAU V. S.

APR 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 47

3832

03832

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN lb 71 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| d. STREET ADDRESS 506 West Preston Street | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ALEXANDER Middle SPENCER Last | | | | 4. DATE OF DEATH Month April Day 23 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 27, 1881 | |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY Clothing Store | | 11. BIRTHPLACE (State or foreign country) Lutherville, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME Alexander Spencer | | | | 14. MOTHER'S MAIDEN NAME Frances Ayers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW I | | 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PROSTATE WITH METASTASES 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema - duration 7 days | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) VA | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that VA attended the deceased from February 11, 1957 , to April 23, 1957 , and that death occurred at 10:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 4/24/57 | | | | | | | |
| ACTUAL SIGNATURE Armen Bogosian M.D. | | | | PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 4-26-57 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | |
| 22d. LOCATION (City, town, or county) Baltimore, Maryland | | | | 22e. (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law | | | | 24a. REC'D BY REGISTRAR DATE 4/24/57 | | 24b. REGISTRAR'S SIGNATURE Lawson L. Farber | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

3833

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|----------------------------------|--|-----------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b <u>1 mo.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u> | | | | d. STREET ADDRESS <u>13209 Hilltop Ave -27</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Margaret E. Spurrier</u> | | | | 4. DATE OF DEATH <u>April 17, 1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-23-75</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 13. FATHER'S NAME <u>George Pieffer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT <u>J.T. Spurrier - son - 3209 Hilltop Ave.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterioscl. Cardiovascular disease</u> DUE TO (c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>Mar 20</u> , 19 <u>57</u> , to <u>April 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 17</u> , 19 <u>57</u> , and that death occurred at <u>7⁰⁰</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>William N. Kahn, Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp 4-17-57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>William N. Kahn, Jr., M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>4-20-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Ritchie 7494 & Co</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Foulson Balto 30 Wd</u> | | | | ADDRESS <u>Balto 30 Wd</u> | | 24a. REC'D BY REGISTRAR <u>APR 22 '57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>—</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03834

3834

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 8 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 2539 E. OLIVER STREET | |
| 3. NAME OF DECEASED First Middle Last GUSTAV (NM) STERBA (also: STERVA) | | 4. DATE OF DEATH Month Day Year APRIL 14, 1957 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-16-93 |
| 9. AGE (In years last birthday) yrs. 63 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER | | 10b. KIND OF BUSINESS OR INDUSTRY CZECHOSLOVAKIA | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME WENCESLAUS STERBA | | 14. MOTHER'S MAIDEN NAME ANNA VOKAC | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1 | | 16. SOCIAL SECURITY NO. 218-32-2302 | |
| 17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 331X DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 10-15 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES; ARTERIOSCLEROTIC HEART DISEASE; PULMONARY EMPHYSEMA-10,15 yrs | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that VA attended the deceased from APRIL 6, 1957 to APRIL 14, 1957 and that death occurred at 9:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, Fort Howard, Md. 4-14-57 ACTUAL SIGNATURE Walter J. Pijanowski M.D. 4-14-57 PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI M.D. VAH, Fort Howard, Md. 4-14-57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-17-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY | | 22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE PHILIP E. CVACH, 2716-18 E. Monument St. Balto. Md. | | 24a. REC'D BY REGISTRAR 4-16-57 | |
| 24b. REGISTRAR'S SIGNATURE Lawson L. Fisher | | | |

[9 - 2]

BUREAU A. S.

APR 17 1957

RECEIVED

3835

CERTIFICATE OF DEATH

Reg. Dist. No.

44

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 47 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 40 Township Road | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ALBERT Middle B. STEWART Last | | | | 4. DATE OF DEATH Month April Day 29 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 22, 1877 | |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Steel Company | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME Joel Stewart | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Ann Turnbaugh | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes | | | | 16. SOCIAL SECURITY NO. Phillipine Ins. 216-10-4026 | | 17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from March 13 , 19 57 , to April 29 , 19 57 , after I last saw the deceased alive on April 29 , 19 57 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND 4/29/57 PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. Chief, Medical Service, VAH, FORT HOWARD, MARYLAND | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-1-57 | | 22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook Inc., St. Paul & Preston Sts., Balto. Md. | | | | 24a. REC'D BY REGISTRAR DATE 4/30/57 | | 24b. REGISTRAR'S SIGNATURE Lawson L. Farley | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

| Age Group | Percentage |
|-----------|------------|
| 18-29 | 85% |
| 30-49 | 75% |
| 50-69 | 65% |
| 70+ | 55% |
| Overall | 70% |

BUREAU V. 1

MAY 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 FilmG214 4-16-57 et

3836

CERTIFICATE OF DEATH

Reg. Dist. No.

03836

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The House in The Pines 16 Fusting Ave | | d. STREET ADDRESS 5601 Ready Avenue | |
| 3. NAME OF DECEASED (Type or print) Bertha M. Stewart | | 4. DATE OF DEATH April 7 1957 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 6, 1890 |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John T. Lucas | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Lawrence Caldwell, 5603 Ready Avenue | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chs. Hypertension Cardio Vascular Disease DUE TO (c) 10 yr. (2) | | INTERVAL BETWEEN ONSET AND DEATH 10 da. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12-28 , 19 56 , to 4-7 , 19 57 , that I last saw the deceased alive on 4-5 , 19 57 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Wilmer K. Gallagher | | M.D. 6209 Frederick Ave. | |
| PHYSICIAN'S NAME (Type) Wilmer K. Gallagher | | Baltimore-28, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-11-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, 1217 St. Paul Street | | ADDRESS | |
| 24a. REC'D BY REGISTRAR APR 10 57 | | DATE | |
| 24b. REGISTRAR'S SIGNATURE Overman | | | |

BUREAU V. 3

APR 10 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3837

CERTIFICATE OF DEATH

Reg. Dist. No. 03837

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 2 Mos. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pardise Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Monterey Middle Randall Last Stiles | | | | 4. DATE OF DEATH Month April Day 2 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 25, 1869 | |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Addison Randell | | | | 14. MOTHER'S MAIDEN NAME Monterey Watson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Norman Stiles | | | | Address 8207 Loch Raven Blvd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 450.0 (c) Arteriosclerosis, generalized, severe DUE TO INTERVAL BETWEEN ONSET AND DEATH 24 hrs Unknown | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from 4-1- , 19 57 , to 4-2- , 19 57 , that I last saw the deceased alive on 4-1- , 19 57 , and that death occurred at 1:30 A. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Stephen Lee Magness M.D. | | | | ADDRESS (Street, city or town, state) 908 Frederick St., Catonsville, Md. | | | |
| DATE SIGNED 4-3-57 | | | | | | | |
| PHYSICIAN'S NAME (Type) STEPHEN LEE MAGNESS | | | | Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 4, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem. | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons | | | | ADDRESS 4905 York Rd. Balto. | | 24a. REC'D BY REGISTRAR 12, Md. | |
| 24b. REGISTRAR'S SIGNATURE Quelan | | | | | | | |

RECEIVED
APR 5 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3838

CERTIFICATE OF DEATH

03838

Reg. Dist. No. 31

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Old Court Rd. Woodlawn</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>John</u> Last <u>Stubble</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 15 1875</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Frederick Stubble</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Lickert</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Frank Stubble - Granite, md.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1957</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan. 1, 1957</u> , to <u>Apr. 2, 1957</u> , that I last saw the deceased alive on <u>Apr. 2, 1957</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Wm. E. Martin</u> | | DATE SIGNED <u>Apr. 2, 1957</u> | |
| PHYSICIAN'S NAME (Type) <u>Wm. E. MARTIN</u> | | ADDRESS (Street, city or town, state) <u>RANDALLSTOWN, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4-5-57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u> | | 22d. LOCATION (City, town, or county) (State) <u>Woodlawn, md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Knight</u> | | ADDRESS <u>Ogdenville, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u> | |
| DATE <u>4-3-57</u> | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED 2. SEX 3. AGE 4. DATE OF BIRTH | | 5. PLACE OF BIRTH 6. OCCUPATION 7. MARITAL STATUS | |
| 8. CAUSE OF DEATH 9. MANNER OF DEATH | | 10. PLACE OF DEATH 11. DATE OF DEATH | |
| 12. SIGNATURE OF PHYSICIAN 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | |
| 15. SIGNATURE OF DECEASED | | 16. SIGNATURE OF NEXT OF KIN | |
| 17. SIGNATURE OF BURIAL OFFICIAL | | 18. SIGNATURE OF FUNERAL HOME | |
| 19. SIGNATURE OF CHURCH OFFICIAL | | 20. SIGNATURE OF CEMETERY OFFICIAL | |
| 21. SIGNATURE OF CORONER | | 22. SIGNATURE OF JURY | |
| 23. SIGNATURE OF JUDGE | | 24. SIGNATURE OF CLERK | |
| 25. SIGNATURE OF SHERIFF | | 26. SIGNATURE OF DEPUTY SHERIFF | |
| 27. SIGNATURE OF CONSTABLE | | 28. SIGNATURE OF DEPUTY CONSTABLE | |
| 29. SIGNATURE OF TOWNSHIP CLERK | | 30. SIGNATURE OF COUNTY CLERK | |
| 31. SIGNATURE OF STATE CLERK | | 32. SIGNATURE OF FEDERAL CLERK | |
| 33. SIGNATURE OF POSTAL CLERK | | 34. SIGNATURE OF TELEGRAPH CLERK | |
| 35. SIGNATURE OF RAILROAD CLERK | | 36. SIGNATURE OF AIRLINE CLERK | |
| 37. SIGNATURE OF MARINE CLERK | | 38. SIGNATURE OF NAVY CLERK | |
| 39. SIGNATURE OF ARMY CLERK | | 40. SIGNATURE OF AIR FORCE CLERK | |
| 41. SIGNATURE OF COAST GUARD CLERK | | 42. SIGNATURE OF CUSTOMS CLERK | |
| 43. SIGNATURE OF INSURANCE CLERK | | 44. SIGNATURE OF BANK CLERK | |
| 45. SIGNATURE OF STOCK EXCHANGE CLERK | | 46. SIGNATURE OF COMMERCE CLERK | |
| 47. SIGNATURE OF AGRICULTURE CLERK | | 48. SIGNATURE OF MINING CLERK | |
| 49. SIGNATURE OF MANUFACTURING CLERK | | 50. SIGNATURE OF TRANSPORTATION CLERK | |
| 51. SIGNATURE OF PUBLIC UTILITIES CLERK | | 52. SIGNATURE OF COMMUNICATIONS CLERK | |
| 53. SIGNATURE OF EDUCATION CLERK | | 54. SIGNATURE OF HEALTH CLERK | |
| 55. SIGNATURE OF SOCIAL WELFARE CLERK | | 56. SIGNATURE OF LABOR CLERK | |
| 57. SIGNATURE OF HOUSING CLERK | | 58. SIGNATURE OF PUBLIC SAFETY CLERK | |
| 59. SIGNATURE OF FIRE DEPARTMENT CLERK | | 60. SIGNATURE OF POLICE DEPARTMENT CLERK | |
| 61. SIGNATURE OF JAIL CLERK | | 62. SIGNATURE OF COURT CLERK | |
| 63. SIGNATURE OF PROBATION CLERK | | 64. SIGNATURE OF PAROLE CLERK | |
| 65. SIGNATURE OF REFORMATORY CLERK | | 66. SIGNATURE OF INSTITUTION CLERK | |
| 67. SIGNATURE OF ASYLUM CLERK | | 68. SIGNATURE OF HOSPITAL CLERK | |
| 69. SIGNATURE OF NURSING HOME CLERK | | 70. SIGNATURE OF BOARDING HOUSE CLERK | |
| 71. SIGNATURE OF RESTAURANT CLERK | | 72. SIGNATURE OF BAR CLERK | |
| 73. SIGNATURE OF CAFE CLERK | | 74. SIGNATURE OF ICEBERG CLERK | |
| 75. SIGNATURE OF MOUNTAIN CLERK | | 76. SIGNATURE OF TROPICAL CLERK | |
| 77. SIGNATURE OF ARCTIC CLERK | | 78. SIGNATURE OF ANTARCTIC CLERK | |
| 79. SIGNATURE OF SPACE CLERK | | 80. SIGNATURE OF TIME CLERK | |
| 81. SIGNATURE OF SPACE-TIME CLERK | | 82. SIGNATURE OF UNIVERSE CLERK | |
| 83. SIGNATURE OF COSMOS CLERK | | 84. SIGNATURE OF UNIVERSE CLERK | |
| 85. SIGNATURE OF COSMOS CLERK | | 86. SIGNATURE OF UNIVERSE CLERK | |
| 87. SIGNATURE OF COSMOS CLERK | | 88. SIGNATURE OF UNIVERSE CLERK | |
| 89. SIGNATURE OF COSMOS CLERK | | 90. SIGNATURE OF UNIVERSE CLERK | |
| 91. SIGNATURE OF COSMOS CLERK | | 92. SIGNATURE OF UNIVERSE CLERK | |
| 93. SIGNATURE OF COSMOS CLERK | | 94. SIGNATURE OF UNIVERSE CLERK | |
| 95. SIGNATURE OF COSMOS CLERK | | 96. SIGNATURE OF UNIVERSE CLERK | |
| 97. SIGNATURE OF COSMOS CLERK | | 98. SIGNATURE OF UNIVERSE CLERK | |
| 99. SIGNATURE OF COSMOS CLERK | | 100. SIGNATURE OF UNIVERSE CLERK | |

BUREAU V. S.

APR 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0383944

3839

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 4 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JOHN G. STROMSKEY | | | | 4. DATE OF DEATH Month April Day 26 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/30/88 | 9. AGE (In years lost birthday) yrs. 68 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man | | | | 10b. KIND OF BUSINESS OR INDUSTRY Gas Company | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Barthalomea Stromskey | | | | 14. MOTHER'S MAIDEN NAME Catherine Sayonas | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI | | | | 16. SOCIAL SECURITY NO. 220-03-0609 | | | |
| 17. INFORMANT Clin. Recs. Vets. Admkn. Hospital, Ft. Howard, Md. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCTION RIGHT SIDE 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL THROMBOSIS RIGHT SIDE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LEFT HEMIPLEGIA, HYPERTENSION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 5 DAYS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from April 22 , 19 57 , to April 26 , 19 57 , and that death occurred at 8:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 4/27/57 ACTUAL SIGNATURE Armen Bogosian M.D. PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M D. Fort Howard, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 5/1/57 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | |
| 22d. LOCATION (City, town, or county) Baltimore, Maryland | | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. | | | | ADDRESS 6009 Harford Rd. | | 24a. REC'D BY REGISTRAR DATE 4/30/57 | |
| 24b. REGISTRAR'S SIGNATURE Dawson L. Farley | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---------------------------------------|--|--|--|
| Name of Deceased JOHN | | Sex Male | | Age 30 | |
| Date of Death April 22, 1957 | | Place of Death Baltimore | | Cause of Death Ischemic Heart Disease | |
| Signature of Physician [Signature] | | Signature of Registrar [Signature] | | Signature of Informant [Signature] | |
| Address of Deceased 1234 Main St. Baltimore, Md. | | Occupation Salesman | | Usual Residence Baltimore, Md. | |
| Manner of Death Natural | | Place of Burial Greenwood Cemetery | | Date of Burial April 25, 1957 | |
| Name of Informant John Doe | | Relationship Son | | Signature of Informant [Signature] | |
| Name of Registrar Jane Smith | | Signature of Registrar [Signature] | | Date of Registration April 23, 1957 | |

BUREAU V. 3

APR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03840
33-

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u> | | c. LENGTH OF STAY IN 1b <u>15 yrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Rd.</u> | | d. STREET ADDRESS <u>Ridge Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Carrie</u> First <u>C. Sultzbaugh</u> Middle <u>C.</u> Last <u>Sultzbaugh</u> | | 4. DATE OF DEATH <u>April</u> Month <u>5</u> Day <u>1957</u> Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 18/1872</u> yrs. <u>85</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Shamokin, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>William W. Still</u> | | 14. MOTHER'S MAIDEN NAME <u>Sophia Wert</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Informant</u> | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u> |
|---|--|---|

| | | |
|---|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Asthma</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|---|--|--|

| | | | |
|--|------------------|---|--|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. <u>19</u> p. m. | Month, Day, Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | |

21. I certify that I attended the deceased from 5-30, 1956, to 4-2, 1957, that I last saw the deceased alive on 4-2, 1957, and that death occurred at 3:20 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) New Freedom, Pa. DATE SIGNED 4-5-57

ACTUAL SIGNATURE R. Robinson M.D. New Freedom, Pa.

PHYSICIAN'S NAME (Type) RICHARD ROBINSON

| | | | |
|---|---------------------------------------|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>April 7/1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Parkton Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> | | 24a. REC'D BY REGISTRAR <u>5/6/57</u> | |
| ADDRESS <u>New Freedom, Pa.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Schlesinger & Freeland</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|-----------------------|--|----------------------|--|-----------------------|--|-------------------------|--|-----------------------|--|----------------------|--|-----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| MAY 1900 | | MALE | | 25 | | MAY 1900 | | BALTIMORE | | MD | | MD | | USA | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | | POST-MORTEM | |
| MAY 1900 | | BALTIMORE | | HEART DISEASE | | NATURAL | | CORONARY ARTERY DISEASE | | PAIN IN CHEST | | MEDICINE | | NO | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | |
| J. H. B. B. B. | | J. H. B. B. B. | | J. H. B. B. B. | | J. H. B. B. B. | | J. H. B. B. B. | | J. H. B. B. B. | | J. H. B. B. B. | | J. H. B. B. B. | |
| DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | DISEASE | | SYMPTOMS | | TREATMENT | | POST-MORTEM | |
| MAY 1900 | | BALTIMORE | | HEART DISEASE | | NATURAL | | CORONARY ARTERY DISEASE | | PAIN IN CHEST | | MEDICINE | | NO | |

BUREAU V. S.

APR 9 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

384 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0384144

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Xo Sparrows Point</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>18 Willow Avenue</u> | | | | d. STREET ADDRESS <u>18 Willow Avenue</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Clyde W. Swift</u> | | | | 4. DATE OF DEATH Month Day Year <u>April 24 1957</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2/19/06</u> | | | |
| 9. AGE (In years last birthday) <u>51</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tractor Operator</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wire Mill</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | | | |
| 13. FATHER'S NAME <u>Howard Swift</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ida Walker</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | | |
| 17. INFORMANT <u>Dolores Swift</u> | | | | Address <u>18 Willow Rd. Sparrows Point.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Jack Collins</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>JACK E Collins</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>4/27/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u> | | | |
| 22d. LOCATION (City, town, or county) <u>Baltimore Maryland</u> | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Flynn & Fleming</u> | | | | ADDRESS <u>1426 Light St. Balto. 30, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 29 1957</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u> | | | | | | | | | |

BUREAU V. 81

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03842
Reg. Dist. No. 42

3705

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2341 MONUMENTAL AVE. | | | | d. STREET ADDRESS 2341 Monumental Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First DOROTHY Middle CARTER Last TANNER | | | | 4. DATE OF DEATH Month April Day 25 Year 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH SEPT 8 1938 | |
| 9. AGE (In years last birthday) 18 yrs. | | IF UNDER 1 YEAR Months 18 Days 18 | | IF UNDER 24 HRS. Hours 18 Min. 18 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) SEVERNA PARK MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HAROLD D. CARTER | | | | 14. MOTHER'S MAIDEN NAME DOROTHY RAVENSCROFT | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Address #14 ARNOLD MD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds of head and neck 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) — (c) — DUE TO (c) — </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 12:10 PM 4/25/1957 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Baltimore, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Russell S. Fisher M.D. | | | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 4/25/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 4-28-1957 Ashbury M.E. CEM. | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY ARNOLD MD | | 22d. LOCATION (City, town, or county) (State) ARNOLD MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR SONS ANNAPOLIS MD | | | | 24a. REC'D BY REGISTRAR DATE April 26 1957 | | | |
| 24b. REGISTRAR'S SIGNATURE John M. Taylor | | | | 24c. REGISTRAR'S SIGNATURE John M. Taylor | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 30 1957

RECEIVED

3842

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 2 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Blackwell Care Home 403 Glenmore Ave. | | | | d. STREET ADDRESS 403 Glenmore Ave. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Teepe, Theresa | | | | 4. DATE OF DEATH Month Day Year April 23, 1957 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-27-02 | |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic (?) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 12. CITIZEN OF WHAT COUNTRY? Unknown | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heartfailure 410x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral stenosis and insufficiency DUE TO (c) Rhumatic Cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 6 mo. 20 yrs. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 27, 1956 , to April 23, 1957 , that I last saw the deceased alive on April 21, 1957 , and that death occurred at 6:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6014 Edmondson Ave. DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE J. Nelson McKay M.D. 6014 Edmondson Ave. | | | | | | | |
| PHYSICIAN'S NAME (Type) J. Nelson McKay, M.D. Baltimore 28, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY Antony Board of M. Balto, Md. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE MAY 10 57 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE Overland | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. B.

APR 13 1957

RECEIVED

CERTIFICATE OF DEATH

03843

Reg. Dist. No.

3843

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3843-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Nursing Home | | d. STREET ADDRESS The Broadview Apts. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First DAVID Middle D. Last THOMAS, SR. | | 4. DATE OF DEATH Month April Day 29 Year 1957 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 16, 1871 |
| 9. AGE (In years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Manager | | 10b. KIND OF BUSINESS OR INDUSTRY Shipyard | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME David D. Thomas | | 14. MOTHER'S MAIDEN NAME Harriet A. Trundle | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 214-10-0125 | |
| 17. INFORMANT Mr. David D. Thomas, Jr. | | Address Balto. 10, Md. 215 Ridgemed Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pericardial pneumonia 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 10 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis - generalized & cerebral | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/24/53 , 19____, to 4/24/57 , 19____, that I last saw the deceased alive on 4/22/57 , 19____, and that death occurred at 8 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Francis M. Glick | | ADDRESS (Street, city or town, state) 102 W. University Hwy DATE SIGNED 4/30/57 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5/2/57 | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | 22d. LOCATION (City, town, or county) (State) Pikesville, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto. | | 24a. REC'D BY REGISTRAR MAY 2 1957 24b. REGISTRAR'S SIGNATURE A. H. Hedrick | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MAY 2 1957

RECEIVED

3844 CERTIFICATE OF DEATH

0384438

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Xo Riderwood</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1409 Walnut Ave.</u> | | | | d. STREET ADDRESS <u>1409 Walnut Ave.</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>NELSON</u> Last <u>TILLMAN</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>19 57</u> | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 22, 1880</u> | | 9. AGE (In years last birthday) <u>76</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Franklin D. Nelson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Ella Taisey</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Mr. Richard N. Tillman - 1409 Walnut Ave</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease, mitral and aortic valve involvement</u> DUE TO (c) <u>10 years</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, cerebral, coronary and peripheral</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>40</u> , to <u>April 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>57</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Richard N. Tillman</u> M.D. <u>3035 St. Paul St.</u> PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>3/16/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Crematory</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mr. J. Lieber & Sons, Balto 17, Md.</u> 24a. REC'D BY REGISTRAR DATE <u>APR 15 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Markel Gray</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3695 Item 7 Film 6214 4-26-57 et
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03845

Reg. Dist. No.

41

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bundall | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Bundall | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 109 Avondale Road | | d. STREET ADDRESS 1 109 Avondale Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First BURLEY Middle TYLER Last TYLER | | 4. DATE OF DEATH Month April Day 17 Year 1957 | |
| 5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 1-1-12 | | 9. AGE (In years last birthday) 45 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger | | 10b. KIND OF BUSINESS OR INDUSTRY Self Employed | |
| 11. BIRTHPLACE (State or foreign country) Richmond, Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Grant Tyler | | 14. MOTHER'S MAIDEN NAME Susie Dandridge | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address Mrs. Charles E. Parrish - 109 Avondale Road | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Liver 581.0 Conditions, if any, which gave rise to immediate cause (b) Lobar Pneumonia (c) DOE TO (c) DOE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Paul F. Guerin | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Paul F. Guerin, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 4/18/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 4-22-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law | | ADDRESS 802 Madison Avenue | |
| 24a. REC'D BY REGISTRAR APR 22 1957 | | 24b. REGISTRAR'S SIGNATURE Am. Kelly | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|------------------------|--|-------------------------------|--|
| Deceased | | Residence | |
| Name | | Address | |
| Age | | Sex | |
| Race | | Color | |
| Date of Birth | | Date of Death | |
| Place of Birth | | Cause of Death | |
| Occupation | | Manner of Death | |
| Signature of Physician | | Signature of Medical Examiner | |
| Date | | Time | |
| Place | | City | |
| State | | County | |

BUREAU V. 2

APR 23 1957

RECEIVED

| | | | |
|------------------------|--|-------------------------------|--|
| Name | | Address | |
| Age | | Sex | |
| Race | | Color | |
| Date of Birth | | Date of Death | |
| Place of Birth | | Cause of Death | |
| Occupation | | Manner of Death | |
| Signature of Physician | | Signature of Medical Examiner | |
| Date | | Time | |
| Place | | City | |
| State | | County | |

3845

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore Co.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u> | | | | c. LENGTH OF STAY IN 1b <u>6 Mos.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Mt. Wilson State Hosp.</u> | | | | d. STREET ADDRESS <u>55 Towson</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Updike</u> Last <u>Updike</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/29/13</u> | |
| 9. AGE (In years last birthday) <u>43</u> yrs. | | IF UNDER 1 YEAR Months <u>4</u> Days <u></u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>?</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Turner Ashby Updike</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Olivia Maddox</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>218-09-1902</u> | | 17. INFORMANT <u>Hospital Reports, Mt. Wilson State Hospital</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis, Far Advanced</u> DUE TO <u>post operative pulmonary resection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month <u>10</u> Day <u>31</u> Year <u>1956</u> Hour <u></u> o. m. <u></u> p. m. <u></u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>10-31</u> , 19 <u>56</u> , to <u>4-19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-19</u> , 19 <u>57</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u> DATE SIGNED <u></u> | | | | | | | |
| ACTUAL SIGNATURE <u>William Newcomer</u> M.D. <u></u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>WILLIAM NEWCOMER, M. D., SUPERINTENDENT</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/24/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Front Royal VA</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Maddox Funeral Home</u> | | | | 24a. REC'D BY REGISTRAR <u></u> | | 24b. REGISTRAR'S SIGNATURE <u>Martha A. Newell</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Page One of Two

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | | 3. AGE [Faint text] | | 4. DATE OF BIRTH [Faint text] | |
| 5. PLACE OF BIRTH [Faint text] | | 6. OCCUPATION [Faint text] | | 7. MARITAL STATUS [Faint text] | | 8. COLOR [Faint text] | |
| 9. DATE OF DEATH [Faint text] | | 10. TIME OF DEATH [Faint text] | | 11. PLACE OF DEATH [Faint text] | | 12. CAUSE OF DEATH [Faint text] | |
| 13. MEDICAL HISTORY [Faint text] | | 14. PRESENT ILLNESS [Faint text] | | 15. POST-MORTEM [Faint text] | | 16. SIGNATURE OF PHYSICIAN [Faint text] | |
| 17. SIGNATURE OF REGISTRAR [Faint text] | | 18. SIGNATURE OF WITNESS [Faint text] | | 19. SIGNATURE OF DECEASED [Faint text] | | 20. SIGNATURE OF NEXT OF KIN [Faint text] | |

BUREAU V. 2

MAY 6 1957

RECEIVED

3846
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 11 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Grace Middle Sidney Last Crissman VanWerven | | | | 4. DATE OF DEATH Month April Day 21 Year 19 57 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 15, 1890 | 9. AGE (In years last birthday) 66 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) social worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Colorado | |
| 13. FATHER'S NAME unknown | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 529-03-7118 | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nodular cirrhosis of the liver | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 11, 1957 , to April 21, 1957 , that I last saw the deceased alive on April 21, 1957 , and that death occurred at 8:35 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-21-57 | | | | | | | |
| ACTUAL SIGNATURE Stella Wachslor M.D. | | | | PHYSICIAN'S NAME (Type) Stella Wachslor, M. D. Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 4/24/57 | | Cedar Hill | | Suitland Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Sumner Burs | | | | 24a. REC'D BY REGISTRAR DATE APR 23 '57 | | 24b. REGISTRAR'S SIGNATURE W. H. Beach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03848

3847

CERTIFICATE OF DEATH

Reg. Dist. No.

44

| | | | | | | | |
|---|---|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 40 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 2620 Ashland Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First LOUIS Middle Last WALTHER | | | | 4. DATE OF DEATH Month April Day 1 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 23, 1877 | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter | | | | 10b. KIND OF BUSINESS OR INDUSTRY Construction Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME John Walther | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 14. MOTHER'S MAIDEN NAME Margaret Arnes | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) SAW | | 16. SOCIAL SECURITY NO. 215-03-6730 | | 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL. 147x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF HYPOPHARYNX DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 5 MONTHS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from February 20, 1957 to April 1, 1957 and that death occurred at 7:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 4/1/57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4/4/57 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | 22d. LOCATION (City, town, or county) Baltimore, Maryland | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St. | | 24. REG. BY REGISTRAR APR 3 1957 | 24b. REGISTRAR'S SIGNATURE Dawson L. Ferber | | | | |

Schimunek Funeral Home, 2601 E. Madison St., Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03849

3848

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home, Harlem | | d. STREET ADDRESS 1403 McHenry St | |
| 3. NAME OF DECEASED (Type or print) First Peter E. Middle Weaver Last Weaver | | 4. DATE OF DEATH Month April Day 26 Year 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 8, 1868 |
| 9. AGE (In years last birthday) 89 yrs. | | IF UNDER 1 YEAR Months 89 Days 89 Hours 89 Min. 89 | IF UNDER 24 HRS. Months 89 Days 89 Hours 89 Min. 89 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Potomac Coal Co. Balto. Md. | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? Unknown | |
| 13. FATHER'S NAME Weaver | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 215 18 2142 | | 16. SOCIAL SECURITY NO. 215 18 2142 | |
| 17. INFORMANT Mrs. Dorothy Evans | | Address 1404 Inverness Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio-sclerotic Atherosclerosis 422.1 DUE TO Vascular Disease with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic (c) Semipathy | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 1956, to April 26, 1957 , that I last saw the deceased alive on April 26th , 1957, and that death occurred at 5:03 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3033 W. North Ave. DATE SIGNED APR 30 '57 | | | |
| ACTUAL SIGNATURE M. Paul Byerly M.D. | | PHYSICIAN'S NAME (Type) M. Paul Byerly | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/29/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY London Park | | 22d. LOCATION (City, town, or county) (State) Baltimore 29 Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors | | 24a. REC'D BY REGISTRAR APR 30 '57 | |
| 24b. REGISTRAR'S SIGNATURE Witzke | | 24c. ADDRESS 4101 Edmondson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03850

3849

CERTIFICATE OF DEATH

Reg. Dist. No.

44

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4136 Beachwood Road | | | | d. STREET ADDRESS 4136 Beachwood Road | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle G. Last Weinhold | | | | 4. DATE OF DEATH Month April Day 8 Year 19 57 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 9, 1901 | | 9. AGE (In years last birthday) 56 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 13. FATHER'S NAME Bernard Weinhold | | | | 14. MOTHER'S MAIDEN NAME Susanna Gress | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-07-1618 | | 17. INFORMANT Mrs. Margaret Weinhold | | Address 4136 Beachwood Road | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 42a.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension Cardio-vascular disease 6 years. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 6, 1954 , to April 8, 1957 , that I last saw the deceased alive on April 8, 1957 , and that death occurred at 10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Eugene F. Nevey M.D. 7001 Mornington Rd. 4-10-57 Dunblazer, MD | | | | | | | |
| ACTUAL SIGNATURE Eugene F. Nevey | | PHYSICIAN'S NAME (Type) Eugene F. Nevey MD | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 12, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Sacred Heart | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St. | | | | 24a. REC'D BY REGISTRAR DATE 4/10/57 | | 24b. REGISTRAR'S SIGNATURE Dunblazer | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

| | | | | | |
|-----------------------------|--|-------------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. PLACE OF BIRTH | | 5. OCCUPATION | | 6. MARITAL STATUS | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. CAUSE OF DEATH | |
| 10. PLACE OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| 13. SIGNATURE OF WITNESSES | | 14. SIGNATURE OF FUNERAL HOME | | 15. SIGNATURE OF BURIAL PLACE | |
| 16. SIGNATURE OF CORONER | | 17. SIGNATURE OF JURY | | 18. SIGNATURE OF JUDGE | |
| 19. SIGNATURE OF PROSECUTOR | | 20. SIGNATURE OF DEFENSE | | 21. SIGNATURE OF JURY | |
| 22. SIGNATURE OF JUDGE | | 23. SIGNATURE OF PROSECUTOR | | 24. SIGNATURE OF DEFENSE | |
| 25. SIGNATURE OF JURY | | 26. SIGNATURE OF JUDGE | | 27. SIGNATURE OF PROSECUTOR | |
| 28. SIGNATURE OF DEFENSE | | 29. SIGNATURE OF JURY | | 30. SIGNATURE OF JUDGE | |
| 31. SIGNATURE OF PROSECUTOR | | 32. SIGNATURE OF DEFENSE | | 33. SIGNATURE OF JURY | |
| 34. SIGNATURE OF JUDGE | | 35. SIGNATURE OF PROSECUTOR | | 36. SIGNATURE OF DEFENSE | |
| 37. SIGNATURE OF JURY | | 38. SIGNATURE OF JUDGE | | 39. SIGNATURE OF PROSECUTOR | |
| 40. SIGNATURE OF DEFENSE | | 41. SIGNATURE OF JURY | | 42. SIGNATURE OF JUDGE | |
| 43. SIGNATURE OF PROSECUTOR | | 44. SIGNATURE OF DEFENSE | | 45. SIGNATURE OF JURY | |
| 46. SIGNATURE OF JUDGE | | 47. SIGNATURE OF PROSECUTOR | | 48. SIGNATURE OF DEFENSE | |
| 49. SIGNATURE OF JURY | | 50. SIGNATURE OF JUDGE | | 51. SIGNATURE OF PROSECUTOR | |
| 52. SIGNATURE OF DEFENSE | | 53. SIGNATURE OF JURY | | 54. SIGNATURE OF JUDGE | |
| 55. SIGNATURE OF PROSECUTOR | | 56. SIGNATURE OF DEFENSE | | 57. SIGNATURE OF JURY | |
| 58. SIGNATURE OF JUDGE | | 59. SIGNATURE OF PROSECUTOR | | 60. SIGNATURE OF DEFENSE | |
| 61. SIGNATURE OF JURY | | 62. SIGNATURE OF JUDGE | | 63. SIGNATURE OF PROSECUTOR | |
| 64. SIGNATURE OF DEFENSE | | 65. SIGNATURE OF JURY | | 66. SIGNATURE OF JUDGE | |
| 67. SIGNATURE OF PROSECUTOR | | 68. SIGNATURE OF DEFENSE | | 69. SIGNATURE OF JURY | |
| 70. SIGNATURE OF JUDGE | | 71. SIGNATURE OF PROSECUTOR | | 72. SIGNATURE OF DEFENSE | |
| 73. SIGNATURE OF JURY | | 74. SIGNATURE OF JUDGE | | 75. SIGNATURE OF PROSECUTOR | |
| 76. SIGNATURE OF DEFENSE | | 77. SIGNATURE OF JURY | | 78. SIGNATURE OF JUDGE | |
| 79. SIGNATURE OF PROSECUTOR | | 80. SIGNATURE OF DEFENSE | | 81. SIGNATURE OF JURY | |
| 82. SIGNATURE OF JUDGE | | 83. SIGNATURE OF PROSECUTOR | | 84. SIGNATURE OF DEFENSE | |
| 85. SIGNATURE OF JURY | | 86. SIGNATURE OF JUDGE | | 87. SIGNATURE OF PROSECUTOR | |
| 88. SIGNATURE OF DEFENSE | | 89. SIGNATURE OF JURY | | 90. SIGNATURE OF JUDGE | |
| 91. SIGNATURE OF PROSECUTOR | | 92. SIGNATURE OF DEFENSE | | 93. SIGNATURE OF JURY | |
| 94. SIGNATURE OF JUDGE | | 95. SIGNATURE OF PROSECUTOR | | 96. SIGNATURE OF DEFENSE | |
| 97. SIGNATURE OF JURY | | 98. SIGNATURE OF JUDGE | | 99. SIGNATURE OF PROSECUTOR | |
| 100. SIGNATURE OF DEFENSE | | 101. SIGNATURE OF JURY | | 102. SIGNATURE OF JUDGE | |

RECEIVED
APR 11 1957
BUREAU VI

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3850 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03851

Reg. Dist. No.

45

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AT Home</u> | | | | d. STREET ADDRESS <u>11617 Rickenbacker Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Wein</u> Last <u>Kam</u> | | | | 4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1957</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-30-85</u> | |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> | | IF UNDER 24 HRS. Hours <u>19</u> Min. <u>57</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> | | 11. BIRTHPLACE (State or foreign country) <u>M.D.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>ANDREW WEINKAM</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MAKER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>213-03-1592A</u> | | 17. INFORMANT <u>ETTA M. WEINKAM</u> Address <u>SAME</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u> DUE TO (c) <u>2 hrs</u> INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Jack Collins</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Jack Collins</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>4-6-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>SACRED-HEART</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTO. M.D.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly, Essex Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>APR 9 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u> | |

RECEIVED
APR 9 1957
BUREAU V. S.

APR 9 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

0385241

3695

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Balto. County MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | | | c. LENGTH OF STAY IN 1b 5 yrs | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 69 Admiral Blvd. | | | | e. STREET ADDRESS / 69 Admiral Blvd. | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle F. Last Weisbecker | | | | 4. DATE OF DEATH Month April Day 3 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 3, 1880 | |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months 76 Days 76 | | IF UNDER 24 HRS. Hours 76 Min. 76 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R. | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME George Weisbecker | | | | 14. MOTHER'S MAIDEN NAME Caroline Hilsman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None | | | | 16. SOCIAL SECURITY NO. None | | | |
| 17. INFORMANT George T. Weisbecker, Son, | | | | Address 69 Admiral Blvd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO A-s-c-v Disease & Heart Block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 yrs. DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour 19 a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE M.B. Davis | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) M.B. DAVIS M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 6/57 | | 22c. NAME OF CEMETERY OR CREMATORY Landon Park | | 22d. LOCATION (City, town, or county) (State) Baltimore 29, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witke | | | | ADDRESS 4101 Edmondson | | 24a. RECEIVED BY REGISTRAR APR 8 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Am. Kelly | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU V. 81
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--------------------------------------|--|------------------------------------|--|---------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF ATTENDING PHYSICIAN | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF WITNESSES | | 17. SIGNATURE OF FUNERAL HOME | | 18. SIGNATURE OF BURIAL PLACE | |
| 19. SIGNATURE OF VITAL RECORDS | | 20. SIGNATURE OF HEALTH DEPARTMENT | | 21. SIGNATURE OF STATE ARCHIVES | |
| 22. SIGNATURE OF COUNTY ARCHIVES | | 23. SIGNATURE OF CITY ARCHIVES | | 24. SIGNATURE OF TOWN ARCHIVES | |
| 25. SIGNATURE OF VITAL RECORDS | | 26. SIGNATURE OF HEALTH DEPARTMENT | | 27. SIGNATURE OF STATE ARCHIVES | |
| 28. SIGNATURE OF COUNTY ARCHIVES | | 29. SIGNATURE OF CITY ARCHIVES | | 30. SIGNATURE OF TOWN ARCHIVES | |
| 31. SIGNATURE OF VITAL RECORDS | | 32. SIGNATURE OF HEALTH DEPARTMENT | | 33. SIGNATURE OF STATE ARCHIVES | |
| 34. SIGNATURE OF COUNTY ARCHIVES | | 35. SIGNATURE OF CITY ARCHIVES | | 36. SIGNATURE OF TOWN ARCHIVES | |
| 37. SIGNATURE OF VITAL RECORDS | | 38. SIGNATURE OF HEALTH DEPARTMENT | | 39. SIGNATURE OF STATE ARCHIVES | |
| 40. SIGNATURE OF COUNTY ARCHIVES | | 41. SIGNATURE OF CITY ARCHIVES | | 42. SIGNATURE OF TOWN ARCHIVES | |
| 43. SIGNATURE OF VITAL RECORDS | | 44. SIGNATURE OF HEALTH DEPARTMENT | | 45. SIGNATURE OF STATE ARCHIVES | |
| 46. SIGNATURE OF COUNTY ARCHIVES | | 47. SIGNATURE OF CITY ARCHIVES | | 48. SIGNATURE OF TOWN ARCHIVES | |
| 49. SIGNATURE OF VITAL RECORDS | | 50. SIGNATURE OF HEALTH DEPARTMENT | | 51. SIGNATURE OF STATE ARCHIVES | |
| 52. SIGNATURE OF COUNTY ARCHIVES | | 53. SIGNATURE OF CITY ARCHIVES | | 54. SIGNATURE OF TOWN ARCHIVES | |
| 55. SIGNATURE OF VITAL RECORDS | | 56. SIGNATURE OF HEALTH DEPARTMENT | | 57. SIGNATURE OF STATE ARCHIVES | |
| 58. SIGNATURE OF COUNTY ARCHIVES | | 59. SIGNATURE OF CITY ARCHIVES | | 60. SIGNATURE OF TOWN ARCHIVES | |
| 61. SIGNATURE OF VITAL RECORDS | | 62. SIGNATURE OF HEALTH DEPARTMENT | | 63. SIGNATURE OF STATE ARCHIVES | |
| 64. SIGNATURE OF COUNTY ARCHIVES | | 65. SIGNATURE OF CITY ARCHIVES | | 66. SIGNATURE OF TOWN ARCHIVES | |
| 67. SIGNATURE OF VITAL RECORDS | | 68. SIGNATURE OF HEALTH DEPARTMENT | | 69. SIGNATURE OF STATE ARCHIVES | |
| 70. SIGNATURE OF COUNTY ARCHIVES | | 71. SIGNATURE OF CITY ARCHIVES | | 72. SIGNATURE OF TOWN ARCHIVES | |
| 73. SIGNATURE OF VITAL RECORDS | | 74. SIGNATURE OF HEALTH DEPARTMENT | | 75. SIGNATURE OF STATE ARCHIVES | |
| 76. SIGNATURE OF COUNTY ARCHIVES | | 77. SIGNATURE OF CITY ARCHIVES | | 78. SIGNATURE OF TOWN ARCHIVES | |
| 79. SIGNATURE OF VITAL RECORDS | | 80. SIGNATURE OF HEALTH DEPARTMENT | | 81. SIGNATURE OF STATE ARCHIVES | |
| 82. SIGNATURE OF COUNTY ARCHIVES | | 83. SIGNATURE OF CITY ARCHIVES | | 84. SIGNATURE OF TOWN ARCHIVES | |
| 85. SIGNATURE OF VITAL RECORDS | | 86. SIGNATURE OF HEALTH DEPARTMENT | | 87. SIGNATURE OF STATE ARCHIVES | |
| 88. SIGNATURE OF COUNTY ARCHIVES | | 89. SIGNATURE OF CITY ARCHIVES | | 90. SIGNATURE OF TOWN ARCHIVES | |
| 91. SIGNATURE OF VITAL RECORDS | | 92. SIGNATURE OF HEALTH DEPARTMENT | | 93. SIGNATURE OF STATE ARCHIVES | |
| 94. SIGNATURE OF COUNTY ARCHIVES | | 95. SIGNATURE OF CITY ARCHIVES | | 96. SIGNATURE OF TOWN ARCHIVES | |
| 97. SIGNATURE OF VITAL RECORDS | | 98. SIGNATURE OF HEALTH DEPARTMENT | | 99. SIGNATURE OF STATE ARCHIVES | |
| 100. SIGNATURE OF COUNTY ARCHIVES | | 101. SIGNATURE OF CITY ARCHIVES | | 102. SIGNATURE OF TOWN ARCHIVES | |

BUREAU V. 81

APR 8 1957

RECEIVED

3851

CERTIFICATE OF DEATH

Reg. Dist. No. 38

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville | | | | c. LENGTH OF STAY IN 1b x 2 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1717 Kurtz Avenue | | | | d. STREET ADDRESS 1717 Kurtz Avenue | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) WALTER WEISBROD | | | | 4. DATE OF DEATH Month April , Day 5 , Year 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 12, 1877 | |
| 9. AGE (In years and birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooper- retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Barrel Mfg. Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Conrad Weisbrod | | | | 14. MOTHER'S MAIDEN NAME Sophia Myers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Family records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER 181x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 6 YRS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from MAR. 18 , 19 57 , to APRIL 5 , 19 57 , that I last saw the deceased alive on APRIL 4 , 19 57 , and that death occurred at 9 P. M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William A. Pillsbury M.D. | | | | ADDRESS (Street, city or town, state) Towson, MD | | | |
| DATE SIGNED 4/5/57 | | | | | | | |
| PHYSICIAN'S NAME (Type) William A. PILLSBURY | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 9, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Towson, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons | | | | ADDRESS Towson, Maryland | | 24a. REC'D BY REGISTRAR April 9 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Mabel C. Gray | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03854

3852

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 25yr3mth24dys | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Welcome, Maryland | | d. STREET ADDRESS Welcome, Maryland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle Welch Last Welch | | 4. DATE OF DEATH Month April Day 22 Year 19 57 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH unknown |
| 9. AGE (In years last birthday) yrs. 80 | | IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min. 80 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Patrick I. Welch | | 14. MOTHER'S MAIDEN NAME Mary ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the esophagus 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from April 12 , 19 57 , to April 22 , 19 57 , that I last saw the deceased alive on April 22 , 19 57 , and that death occurred at 9:55a M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stella Wachslar M.D. | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-22-57 | |
| PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-29-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Spring Grove State Hospital | | 22d. LOCATION (City, town, or county) (State) Catonsville 28, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Spring Grove State Hospital | | 24a. REGISTRY REGISTRAR Catonsville 28, Md. | |

CERTIFICATE OF DEATH

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|-----------------------|--|--------------------------|--|------------------------|--|------------------------|--|----------------------|--|-------------------------------|--|--------------------------|--|------------------------|--|-----------------------|--|---------------------------|--|-----------------------------|--|---------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1910 | | New York City | | New York City | | Heart Disease | | Jan 15, 1957 | | 10:00 AM | | New York City | | John Doe, M.D. | | John Doe, Registrar | |
| Occupation | | Marital Status | | Previous Illnesses | | Medical History | | Family History | | Social History | | Manner of Death | | Burial Place | | Burial Date | | Burial Time | | Burial Place | | Burial Date | |
| Teacher | | Married | | None | | None | | None | | None | | Natural | | New York City | | Jan 15, 1957 | | 10:00 AM | | New York City | | Jan 15, 1957 | |
| Signature of Deceased | | Signature of Next of Kin | | Signature of Physician | | Signature of Registrar | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Pathologist | | Signature of Anatomist | | Signature of Necropsy | | Signature of Toxicologist | | Signature of Bacteriologist | | Signature of Microscopist | |
| None | | None | | None | | None | | None | | None | | None | | None | | None | | None | | None | | None | |

BUREAU V. 3

MAY 1 1957

RECEIVED

3853

CERTIFICATE OF DEATH

Reg. Dist. No.

038558

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|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>800 Weatherbee Road</u> | | | | d. STREET ADDRESS <u>1 800 Weatherbee Road</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Barbara</u> <u>Wenzel</u> | | | | 4. DATE OF DEATH Month Day Year <u>April 5th</u> <u>19 57</u> | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 23, 1868</u> | |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>John Annreich</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Louisa Rudolf</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Mrs. Marie R. Clegg, 800 Weatherbee Road.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS-GENERALIZED - 10 YRS.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>MAR. 4, 1957</u> to <u>APRIL 5, 1957</u> , that I last saw the deceased alive on <u>APRIL 5, 1957</u> , and that death occurred at <u>9:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1532 HAVENWOOD RD</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Arthur Horikarfgly</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>ARTHUR HORIKARFGLY</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/9/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>APR 10 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mabel Guyo</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3854

CERTIFICATE OF DEATH

Reg. Dist. No.

03856

| | | | | | |
|---|------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | d. STREET ADDRESS 702 Edgewood Street | | |
| 3. NAME OF DECEASED (Type or print) First James Middle Albert Last Wertman | | | 4. DATE OF DEATH Month April Day 4 Year 19 57 | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH April 27, 1886 | | 9. AGE (In years last birthday) yrs. 70 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store owner | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Penna. | |
| 13. FATHER'S NAME James Wertman, Sr. | | | 14. MOTHER'S MAIDEN NAME Hattie Schaeffer | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes | | 16. SOCIAL SECURITY NO. 10612-1918 | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 428.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Jan. 3, 1957 , to April 4, 1957 , that I last saw the deceased alive on April 4, 1957 , and that death occurred at 4:15 p.m. , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE Stella Wachslar | | M.D. SPRING GROVE STATE HOSPITAL | | DATE SIGNED 4-4-57 | |
| PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | ADDRESS Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4-8-57 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Max Martenson Catonsville | | 24a. REC'D BY REGISTRAR APR 9 '57 | | 24b. REGISTRAR'S SIGNATURE W. Leach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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|--------------------|--|--------|--|--------|--|---------|--|---------------|--|-------------------|--|------------------|--|------------------|--|-------------------|--|--------------------|--|---------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. DECEASED'S NAME | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | | 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. DATE OF DEATH | | 9. PLACE OF DEATH | | 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | |
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3855

CERTIFICATE OF DEATH

Reg. Dist. No.

03857
44

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| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 23 Hrs. 25 Min. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 2101 W. Cold Spring Lane | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle G. Last WHITE | | | | 4. DATE OF DEATH Month April Day 5 Year 1957 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 25, 1886 | |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months 5 Days 19 Hours 57 | | IF UNDER 24 HRS. Months 5 Days 19 Hours 57 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker | | | | 10b. KIND OF BUSINESS OR INDUSTRY Chicken Farm | | 11. BIRTHPLACE (State or foreign country) Calvert County, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME Gabel White | | | | 14. MOTHER'S MAIDEN NAME Eliza Johnson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. WW 1 | | 17. INFORMANT Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RIGHT HEART FAILURE WITH PULMONARY EDEMA 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 12 Hours Unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE HEMORRHAGIC CYSTITIS | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. VA 19 p. m. 11:00AM | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from April 4, 1957 , to April 5, 1957 , that death occurred at 10:25 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Armen Bogosian M.D. VAH, FORT HOWARD, MARYLAND | | | | DATE SIGNED 4/6/57 | | | |
| PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4-9-57 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. L. Russ ADDRESS 2222 W. North Avenue, Balto., Md. | | | | 24a. REC'D BY REGISTRAR APR 9 1957 | | 24b. REGISTRAR'S SIGNATURE Lawson L. Fisher | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BURMAN A. S.

RECEIVED

3856

CERTIFICATE OF DEATH

Reg. Dist. No.

03858
38

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| 1. PLACE OF DEATH o. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armstrong Nursing Home 812 Regester Ave. | | | | d. STREET ADDRESS 246 W. Lanvale St. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First GRACE Middle N. Last WILLIAMSON | | | | 4. DATE OF DEATH Month Apr. Day 30 Year 1957 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 10, 1905 | | 9. AGE (In years last birthday) 51 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME W. R. Cross | | | | 14. MOTHER'S MAIDEN NAME Mamie Martin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Roger S. Williamson - 246 W. Lanvale St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Memorized 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recurrent Carcinoma of Cervix uteri DUE TO (c) 2 years | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 month | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 4, 1955 , to April 30, 1957 , that I last saw the deceased alive on April 25, 1957 , and that death occurred at 8:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 E. Chase St. DATE SIGNED May 1, 1957 | | | | | | | |
| ACTUAL SIGNATURE Houston S. Everett | | PHYSICIAN'S NAME (Type) Houston S. Everett | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/3/57 | | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | | 22d. LOCATION (City, town, or county) (State) Pikesville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickerson & Sons - Balto 17 | | | | 24a. REC'D BY REGISTRAR MAY 2 1957 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000

BUREAU V. S.

MAY 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03859

3857 CERTIFICATE OF DEATH

Reg. Dist. No.

40

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| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fork | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mount Vista Rd. | | | | e. STREET ADDRESS Mount Vista Rd. | | | |
| 3. NAME OF DECEASED (Type or print) First Emma Middle Willick Last Willick | | | | 4. DATE OF DEATH Month April Day 8 Year 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 6, 1877 | | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Balto. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Cloman | | | | 14. MOTHER'S MAIDEN NAME Cornelia Allender | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mr. Edward G. Willick Address Mt. Vista Rd. Glenarm, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS & MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) — | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Feb. 7 , 19 42 , to 4/8 , 19 57 , that I last saw the deceased alive on 4/8 , 19 57 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Clifford F. Hudson M.D. | | | | ADDRESS (Street, city or town, state) Fork, Md. | | DATE SIGNED 4/9/57 | |
| PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON | | | | FORK, MD. 4/9/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 11, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Fork Methodist | | 22d. LOCATION (City, town, or county) (State) Fork, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lashin Funeral Home | | | | ADDRESS 7401 Belair Rd. | | 24a. REC'D BY REGISTRAR DATE APR 10 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Dr. Walter Bennett | | | |

APR 10 1957
BUREAU V.

RECEIVED

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

03860

47

Reg. Dist. No.

3706

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|---|----------------------------------|--|--|--|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Baltimore County</u> | | STATE <u>MARYLAND</u> | | STATE <u>Maryland</u> | | COUNTY <u>Baltimore</u> | |
| CITY (If outside corporate limits, write RURAL OR end, give nearest town) <u>Baltimore Highlands</u> | | LENGTH OF STAY (in this place) <u>9 yrs.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Xo Baltimore Highlands</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4220 Baltimore Street</u> | | | | STREET ADDRESS (If rural give location) <u>4220 Baltimore Street</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>Elmer E. Wilson</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 29, 1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>January 5, 1897</u> | 9. AGE last birthday <u>60</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Pa. R.R.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>?</u> | | | | 14. MOTHER'S MAIDEN NAME <u>?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>212-14-8462</u> | | 17. INFORMANT & ADDRESS <u>Elizabeth Wilson 4220 Balto. St.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 163x IMMEDIATE CAUSE (A) <u>Carcinoma of Lung</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) _____ | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Tuberculosis, far advanced, arrested</u> | | | | | | <u>1 yr</u> | |
| 19a. DATE OF OPERATION <u>002x</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>University Hospital - Carcinoma Lung -</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>April 25, 1957</u> to <u>April 29, 1957</u> , that I last saw the deceased alive on <u>April 27, 1957</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>A. Bradley Daugherty</u> | | M.D.: <u>1264 Francis Ave Baltimore 27 Md 5-1-57</u> | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>5/3/1957</u> | | NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> | | LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 24. REC'D BY REGISTRAR <u>MAY 3 1957</u> | | REGISTRAR'S SIGNATURE <u>Dr. E. M. Kieffers</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Flynn & Fleming 1426 Light Street.</u> | | ADDRESS | |

CERTIFICATE OF DEATH

May 1957

1. NAME OF DECEASED (Print Name)

2. SEX (Male or Female)

3. AGE (Years)

4. PLACE OF DEATH

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BIRTH

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. RELIGION

13. PREVIOUS ILLNESS

14. PRESENT ILLNESS

15. MEDICAL HISTORY

16. SOCIAL HISTORY

17. PERSONAL HISTORY

18. PHYSICAL EXAMINATION

19. LABORATORY EXAMINATIONS

20. PATHOLOGICAL FINDINGS

21. CLINICAL COURSE

22. TREATMENT

23. PROGNOSIS

24. COMMENTS

25. SIGNATURE OF PHYSICIAN

26. SIGNATURE OF REGISTRAR

27. SIGNATURE OF WITNESSES

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BUREAU V. S.

MAY 3 1957

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1. NAME OF DECEASED (Print Name)
2. SEX (Male or Female)
3. AGE (Years)
4. PLACE OF DEATH
5. DATE OF DEATH
6. TIME OF DEATH
7. CAUSE OF DEATH
8. PLACE OF BIRTH
9. OCCUPATION
10. MARITAL STATUS
11. EDUCATION
12. RELIGION
13. PREVIOUS ILLNESS
14. PRESENT ILLNESS
15. MEDICAL HISTORY
16. SOCIAL HISTORY
17. PERSONAL HISTORY
18. PHYSICAL EXAMINATION
19. LABORATORY EXAMINATIONS
20. PATHOLOGICAL FINDINGS
21. CLINICAL COURSE
22. TREATMENT
23. PROGNOSIS
24. COMMENTS
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26. SIGNATURE OF REGISTRAR
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3858

CERTIFICATE OF DEATH

Reg. Dist. No.

03861

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28 Mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Shady Nook Nursing Home | | d. STREET ADDRESS 235 Oaklee Village | |
| 3. NAME OF DECEASED (Type or print) MARY G WOLF First Middle Last | | 4. DATE OF DEATH April 9, 1957 Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 19, 1884 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Bernard J. Ward | | 14. MOTHER'S MAIDEN NAME Mateldia | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none | | 17. INFORMANT Harry B. Wolf, 4213 Fordham Rd. Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO HYPERTENSIVE ARTERIO SCLEROSIS - CARDIO-VASCULAR DISEASE - PULMONARY EDEMA - ACUTE CORONARY INSUFFICIENCY - PNEUMONIA (HYPOSTATIC) (b) ACUTE CORONARY INSUFFICIENCY (c) PNEUMONIA (HYPOSTATIC) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I (a) | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 6/1 , 19 53 to 4/9 , 19 57 , that I last saw the deceased alive on 4/9 , 19 57 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE John H. Shaw M.D. | | 5800 EDMONDSON AVE. 4/9/57 | |
| PHYSICIAN'S NAME (Type) John H. Shaw M.D. Catonsville 28, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 4-12-57 | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park | 22d. LOCATION (City, town, or county) (State) Baltimore County |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave ADDRESS | | 24a. REC'D BY REGISTRAR APR 15 57 | 24b. REGISTRAR'S SIGNATURE Quinich |

CERTIFICATE OF DEATH

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|------------------------|--|------------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | COUNTRY OF BIRTH | |
| EDWARD J. WARD | | 35 | | M | | W | | 1880 | | BALTIMORE | | BALTIMORE | | UNITED STATES | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | |
| 1234 W. BALTIMORE ST. | | DRUGGIST | | HEART DISEASE | | NATURAL | | 2 WEEKS | | APR 15, 1957 | | BALTIMORE | | BALTIMORE | |
| FATHER'S NAME | | MOTHER'S NAME | | EDUCATION | | RELIGION | | MARRIED | | SINGLE | | WIDOW | | DIVORCED | |
| J. WARD | | M. WARD | | HIGH SCHOOL | | METHODIST | | YES | | NO | | NO | | NO | |
| DATE OF MARRIAGE | | PLACE OF MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | | CITY OF DEATH | | COUNTRY OF DEATH | | STATE OF DEATH | | COUNTY OF DEATH | |
| JAN 1, 1950 | | BALTIMORE | | APR 15, 1957 | | BALTIMORE | | BALTIMORE | | UNITED STATES | | BALTIMORE | | BALTIMORE | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

APR 15, 1957

BUREAU V. 2

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

03862 21

3859

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|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE CITY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOUNT WILSON, Md | | | | c. LENGTH OF STAY IN 1b TEN DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MOUNT WILSON STATE HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE VIRGINIA YAROSHEVICH | | | | 4. DATE OF DEATH Month Day Year April 22 1957 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC. 25 1918 | |
| 9. AGE (In years last birthday) 38 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT WAITRESS | | | | 10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME LOUIS JONES | | | | 14. MOTHER'S MAIDEN NAME EMMA VALENTINE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 214-20-7332 | | 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 002X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNCERTAIN | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from APRIL 12, 1957 , to APRIL 22, 1957 , that I last saw the deceased alive on APRIL 21, 1957 , and that death occurred at 6 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED William Newcomer ACTUAL SIGNATURE William Newcomer M.D. PHYSICIAN'S NAME (Type) WILLIAM NEWCOMER, M. D., SUPERINTENDENT | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF APRIL 25 1957 | | 22c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEM | | 22d. LOCATION (City, town, or county) (State) EASTERN AVE MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Bros ADDRESS 1800 E. LOMBARD ST. | | | | 24. RECEIVED BY REGISTRAR DATE APR 25 1957 REGISTRAR'S SIGNATURE Anthony Newell | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0-07 388-1055

BOREAU V. S.

APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3860 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03863
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Reg. Dist. No.

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|--|--|--|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN 1b 55 Towson | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 315 Lennox Ave. | | | | d. STREET ADDRESS 315 Lennox Ave. | | | |
| 3. NAME OF DECEASED (Type or print) First Fannie Middle I. Last Young | | | | 4. DATE OF DEATH Month April Day 28 Year 1917 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 21, 1878 | |
| 9. AGE (In years last birthday) 79 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) Jackson City, Miss. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Samuel Hill | | | | 14. MOTHER'S MAIDEN NAME Susan Hill | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. Mr. C. Thomas Young Address 315 Lennox Ave. Towson, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardio-renal (c) Vascular Disease cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 Days 5 years |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 1, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | | 22d. LOCATION (City, town, or county) (State) Baltimore Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home 1631 Druid Hill Av | | | | 24a. REC'D BY REGISTRAR MAY 2 1957 | | | |
| 24b. REGISTRAR'S SIGNATURE Mabel Krupp | | | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

MAY 2 1957

RECEIVED

3861

CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u> <u>16 Fusting Ave.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u> | |
| | | d. STREET ADDRESS <u>316 Maryland Rd.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>ZINSER</u> Last <u>ZINSER</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>19 57</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 14, 1885</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman (rtd)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Adolph Zinser</u> | | 14. MOTHER'S MAIDEN NAME <u>Clementine Neuberger</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. Amelia Zinser - 316 Maryland Rd.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 17, 1944</u> , to <u>April 15, 1957</u> , that I last saw the deceased alive on <u>April 15, 1957</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>George A. Knipp</u> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <u>4116 Edmondson Avenue</u> <u>Apr. 16, 1957</u> | |
| PHYSICIAN'S NAME (Type) <u>George A. Knipp, M. D.</u> | | <u>Baltimore 29, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>4/18/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickenor & Sons - Balto</u> | | 24a. REC'D BY REGISTRAR DATE <u>APR 17 57</u> | |
| ADDRESS <u>17th</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. J. Tickenor</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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